

Today's Date: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

**PREVIOUS SURGERIES**

Surgery	Date	Surgery	Date

Have you had any problems with general anesthesia? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

**MEDICATIONS**

List all medications (prescription & over the counter), vitamins/supplements, steroids and inhalers that you are currently taking:

Medication	Dose	How Often	Medication	Dose	How Often

**ALLERGIES**

Allergy	Reaction	Allergy	Reaction

**MEDICAL HISTORY**

Please respond to the following by marking **Y for Yes or N for No**

**Cardiac:**

- Chest pain \_\_\_\_\_
- Palpitations/racing heart \_\_\_\_\_
- Congestive heart failure \_\_\_\_\_
- Heart attack \_\_\_\_\_
- Elevated blood pressure \_\_\_\_\_
- High cholesterol \_\_\_\_\_
- Atrial fibrillation \_\_\_\_\_
- Rheumatic fever \_\_\_\_\_
- Pacemaker \_\_\_\_\_
- Diabetes \_\_\_\_\_

**Respiratory:**

- Wheezing \_\_\_\_\_
- Shortness of breath \_\_\_\_\_
- Productive cough \_\_\_\_\_
- Asthma \_\_\_\_\_
- Emphysema \_\_\_\_\_
- COPD \_\_\_\_\_
- Bronchitis \_\_\_\_\_
- Pneumonia \_\_\_\_\_
- Pulmonary embolism \_\_\_\_\_
- Stroke (CVA/TIA) \_\_\_\_\_

**SOCIAL HISTORY**

Do you smoke or use tobacco? No \_\_\_ Yes \_\_\_ If yes, how much per day? \_\_\_\_\_  
 Have you ever smoked? No \_\_\_ Yes \_\_\_ For how long? \_\_\_\_\_ Date quit? \_\_\_\_\_  
 Do you drink alcohol? No \_\_\_ Yes \_\_\_ How many drinks per day/week/month? \_\_\_\_\_  
 Do you use illicit drugs? No \_\_\_ Yes \_\_\_ If yes, what type? \_\_\_\_\_  
 Are you on a special diet? No \_\_\_ Yes \_\_\_ If yes, describe: \_\_\_\_\_  
 What is/was your occupation? \_\_\_\_\_

**FAMILY HISTORY**

Please indicate if any family member has had any of the following and their relationship to you:

Heart problems/chest pain:	Who? _____	Blood pressure problems:	Who? _____
Stroke/TIA:	Who? _____	Elevated Cholesterol:	Who? _____
Cancer:	Who? _____	Diabetes:	Who? _____
Bleeding problems:	Who? _____	Reaction to anesthesia:	Who? _____
Blood clots:	Who? _____	Varicose veins:	Who? _____

The following are for **chronic or on-going** conditions.

Please respond by marking **C for Currently, P for in the Past, Leave blank if condition does not apply to you.**

<b>Neurological:</b>		<b>Digestive:</b>		<b>Endocrine:</b>	
Numbness:	_____	Abdominal pain	_____	Tired/sluggish	_____
Loss of strength	_____	Nausea	_____	Excessive thirst	_____
Headaches	_____	Constipation	_____	Diabetes	_____
Seizures/epilepsy	_____	Diarrhea	_____	Thyroid problems	_____
Multiple sclerosis	_____	Colitis	_____		
		Diverticulitis	_____	<b>Heent:</b>	
<b>Blood/Immune System:</b>		Hiatal hernia	_____	Ear problems	_____
Swollen glands	_____	Reflux	_____	Eye problems	_____
Anemia	_____	Irritable bowel	_____	Nose/sinus problems	_____
Cirrhosis	_____	Ulcers	_____	Throat problems	_____
DVT/phlebitis/clots	_____	Pancreatitis	_____		
Jaundice	_____	Rectal bleeding	_____	<b>Genitourinary/Gyn:</b>	
				Kidney problems	_____
<b>Musculoskeletal:</b>		<b>Psychological:</b>		Kidney failure	_____
Back/neck problems	_____	Nervousness	_____	Bladder infections	_____
Joint pain	_____	Anxiety	_____	Prostate problems	_____
Arthritis	_____	Depression	_____	Uterine problems	_____
Fractures	_____	Other _____	_____		
Osteoporosis	_____			<b>Communicable Disease:</b>	
Rash/skin breakdown	_____	<b>Constitutional:</b>		AIDS/HIV	_____
		Fever	_____	Hepatitis	_____
		Chills	_____	STD	_____
		Weight loss	_____	Tuberculosis	_____
		Night sweats	_____		

Are you on dialysis? No \_\_\_ Yes \_\_\_ Schedule \_\_\_\_\_

Have you ever been diagnosed with cancer? No \_\_\_ Yes \_\_\_ Type \_\_\_\_\_ Treatment \_\_\_\_\_

Additional information that you feel the doctor should be aware of: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_