Today's Date: _____

Name: _____ Date of Birth: _____

Primary Care Physician: _____ Referring Physician: _____

Other Treating Physicians: _____

ALLERGIES:
Please list all medications, latex, dyes, foods,

Allergy	Reaction

MEDICATIONS:
Please list all medications or drugs including over the counter medications, herbal supplements and vitamins

Drug/Medicine	Amount/Dose	Frequency

DO YOU HAVE OR HAVE YOU HAD: please circle Y or N

HIV or AIDS	Y/N
Diabetes, insulin required	Y/N
Diabetes, Non-Insulin	Y/N
Heart Attack	Y/N
Coronary Artery Disease	Y/N
Heart Arrhythmia	Y/N
Pacemaker	Y/N
Defibrillator	Y/N
Coronary Stents	Y/N
Heart Murmur	Y/N
High Blood Pressure	Y/N
High Cholesterol	Y/N
Stroke or Mini Stroke (TIA)	Y/N
Bleeding Disorder	Y/N
Pulmonary Embolism	Y/N
Deep Vein Thrombosis	Y/N
Peripheral Vascular Disease	Y/N
Asthma	Y/N

Emphysema or COPD	Y/N
Sleep Apnea	Y/N
Pneumonia	Y/N
Tuberculosis	Y/N
Hypothyroidism	Y/N
Hiatal Hernia/Reflux	Y/N
Peptic Ulcer Disease	Y/N
Diverticulitis	Y/N
Hepatitis	Y/N
Liver Disease	Y/N
Urinary Tract Infections	Y/N
Kidney Stones	Y/N
Osteoporosis	Y/N
Fibromyalgia	Y/N
Gout	Y/N
Osteoarthritis	Y/N
Rheumatoid Disease	Y/N
Poliomyelitis	Y/N

Organ Transplant	Y/N
Psoriasis or other skin disease	Y/N
Migraine Headaches	Y/N
Seizure Disorder	Y/N
Psychiatric Disorder	Y/N
Anxiety Disorder	Y/N
Depression	Y/N
Drug Addiction	Y/N
Glaucoma	Y/N
Leukemia/Lymphoma	Y/N
Cancer (list type)	Y/N

Please list other conditions not mentioned:

_____
_____
_____
_____
_____
_____

Name: _____ **Date of Birth: _____**

REVIEW OF SYSTEMS: Have you had any of the following?

HEAD / EARS / EYES
__Y__N Cataracts
__Y__N Recent Change in Vision
__Y__N Head Injury
__Y__N Ringing in the ears
__Y__N Hearing Loss
__Y__N Hearing Aid
Other: _____

NOSE / SINUSES
__Y__N Hay fever/seasonal allergy
__Y__N Frequent nose bleeds
Other: _____

SKIN
__Y__N Skin Cancer
__Y__N Itching
__Y__N Wound healing problems
Other: _____

MOUTH / THROAT
__Y__N Bleeding mouth/gums
__Y__N Difficulty Swallowing
__Y__N Dentures
Other: _____

CARDIAC
__Y__N Frequent chest pains
__Y__N Palpitations
__Y__N Atrial Fibrillation
__Y__N Infection of the heart
Other: _____

PULMONARY
__Y__N Shortness of breath
__Y__N Cough up blood
__Y__N Frequent coughing
__Y__N Wheezing
Other: _____

OB/GYN
__Y__N History of venereal disease
__Y__N Chance you may be pregnant
__Y__N Pregnancies #____Births#____
Last Menstrual period _____
Last Pap Smear _____

BREAST
__Y__N Cancer
__Y__N Pain
__Y__N Masses/lumps
__Y__N Mammogram? When_____

GASTROINTESTINAL
__Y__N Abdominal pain/How long? _____
__Y__N Rectal Bleeding
__Y__N Change in bowel habits
__Y__N Constipation
__Y__N Diarrhea
__Y__N Hemorrhoids
__Y__N Rectal/anal pain, itching, burning
__Y__N Nausea/vomiting
__Y__N Change in appetite
__Y__N Fecal Incontinence/Loss of control

UROLOGIC
__Y__N Increased frequency
__Y__N Dribbling
__Y__N Blood in urine
__Y__N Kidney stones
__Y__N Need to get up at night to urinate
How many times? _____
Other: _____

MUSCULOSKELETAL
__Y__N Joint pain
__Y__N Joint swelling
__Y__N Muscle disorder or problem
Other: _____

NEUROLOGIC
__Y__N Seizure disorder
__Y__N Fainting
__Y__N Numbness in arms or legs
__Y__N Paralysis

VASCULAR
__Y__N Aneurysm
__Y__N History of blood clots

ENDOCRINE
__Y__N Kidney Dialysis
__Y__N Diabetes

IMMUNE
__Y__N Blood transfusion
__Y__N Immunosuppression

SURGERY
__Y__N Problems with anesthesia?
What? _____
__Y__N Prolonged bleeding when cut
__Y__N Latex allergy

Name: _____ Date of Birth: _____

PAST SURGICAL HISTORY - Please list any operations you have had, approximate date or age at time of surgery

		Date / Age			Date / Age
__Y__N	Appendectomy	_____	__Y__N	Cholecystectomy/Gallbladder	_____
__Y__N	Hysterectomy	_____	__Y__N	Wisdom teeth extraction	_____
__Y__N	Hernia Repair	_____	__Y__N	**COLONOSCOPY**	_____
__Y__N	C-section	_____	__Y__N	Prostate	_____
__Y__N	Tubal ligation	_____	__Y__N	Rectal Surgery	_____

Please list any additional surgeries:

Operation	Date / Age
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

1. Marital Status __Single __Married __Divorced __Widowed __Living with significant other

2. Do you now or have you ever smoked or used smokeless tobacco? __Y__N
   If yes, how many packs per day _____ or how many tins/pouches _____ Cigars _____ How many years? _____
   If no, never smoked _____ Past smoker _____ How much did you smoke, when did you quit? _____

3. Do you drink? __Y__N
   If yes, _____ Drinks _____ Beers _____ Wine or Liquor servings per day
   _____ Social - weekly or weekends
   _____ Few times a year only
   _____ Alcoholism / Alcoholism abuse

FAMILY HISTORY - Please list any family members (parents, grandparents, siblings, and children) with any conditions:

__Y__N	Stroke	_____	__Y__N	Colon Polyps	_____
__Y__N	Heart Disease	_____	__Y__N	Colon Cancer	_____
__Y__N	Diabetes	_____	__Y__N	Diverticulitis	_____
__Y__N	Asthma	_____	__Y__N	Crohn's Disease	_____
__Y__N	High Blood Pressure	_____	__Y__N	Ulcerative Colitis	_____
CANCER:					
__Y__N	Breast	_____	__Y__N	Uterine	_____
__Y__N	Ovarian	_____	__Y__N	Stomach	_____
__Y__N	Prostate	_____	__Y__N	Other Cancer:	_____

****

(FOR OFFICE USE ONLY)

UPDATED _____

UPDATED _____

UPDATED _____

UPDATED _____

All systems negative except as marked

_____
Physician Signature

_____
Date