Name: ________________________________ **Date of Birth:** __________________ **Todays Date:** __________________

Why are we seeing you today? ____

SURGICAL HISTORY

Procedure	Surgery Date	Notes

FAMILY HISTORY Please be specific if it is on the Maternal or Paternal side.

Relation	Problem

Relation	Problem

☐ **Any bleeding problems in your family:** ____

☐ **Any problems with anesthesia in your family:** ____

☐ **Family history of blood clots:** ____

☐ **Family History of cancer:** ____

MEDICATIONS If not enough room, please list on back.
Pharmacy: ____

☐ **Any blood thinners or aspirin. If so, specify:** ____

Medication/Dosage	Directions

Medication/Dosage	Directions

Name: ______________________________ Date of Birth: ______________

ALLERGIES

Drug/Allergen	Reaction

Drug/Allergen	Reaction

PAST MEDICAL HISTORY (ONLY mark if YES)

	Yes	Notes		Yes	Notes
ADHD			Developmental/Behavioral Disorders		
Abdominal Pain			Diabetes		
Abnormal Weight Loss			Dialysis		
Affective Disorders			Diarrhea		
Alcohol Use			Difficulty Swallowing		
Allergies			Digestive Problems		
Anemia			Diverticulitis		
Anorexia			Ear or Hearing Problems		
Anxiety Disorder			Ectopic Pregnancy		
Aortic Aneurysm			Emotional Problems		
Appendicitis			Emphysema		
Appetite, poor			Epilepsy		
Arrhythmia			Fibromyalgia		
Arthritis			Gastrointestinal Disease		
Asthma/Breathing Problems			GERD/ Acid Reflux		
Atrial-Fib			German Measles		
Atrial Flutter			Glaucoma		
Bladder or Kidney Problems			Goiter		
Bleeding Disorder			Gonorrhea		
Bloating			Gout		
Blood Disease			HIV Positive		
Bowel Changes			Headaches or Dizziness		
Breast Mass / Cyst			Heart Attack/ MI (angina)		
Broken Bones			Heart Disease		
Bronchitis			Heart Murmur/ Valve Disorder		
Bulimia			Hemorrhoids		
CVA / Stroke			Hepatitis (Acute or Chronic)		
Cancer			Hernia(s)		
Carotid Disease			High Cholesterol		
Cataracts			Hypertension		
Chemical / Drug Dependency			Hyperthyroidism		
Chicken Pox			Hypothyroidism		
COPD			Incontinence: Fecal		
Chronic Pain			Incontinence: Urinary		
Constipation			Indigestion		

Coronary Artery Disease			**Kidney Disease**		
Deep Vein Thrombosis			**MRSA/ Drug Resistant Infections**		
Depression			**Measles**		
Migraine Headaches			**Pulmonary Embolism**		
Miscarriage			**Rectal Bleeding**		
Mononucleosis			**Reflux Disease**		
Mouth Sores			**Rheumatic Fever**		
Multiple Sclerosis			**Scarlet Fever**		
Mumps			**Seizures or Convulsions**		
Muscle/ Joint/ Bone Problem			**Serious/ Traumatic Injuries**		
Nasal Trauma			**Sexually Transmitted Disease**		
Nausea Alone			**Skin Cancer**		
Nausea/ Vomiting			**Skin Problems**		
Organ Transplant			**Sleep Apnea (snoring)**		
Osteopenia			**Suicide Attempt**		
Osteoporosis			**Shortness of Breath**		
Pacemaker			**Tonsilitis**		
Peptic Ulcers			**Tuberculosis**		
Peripheral Vascular Problem			**Typhoid Fever**		
Pneumonia			**Ulcers**		
Polio			**Urinary Tract Infections**		
Poliomyelitis			**Vaginal Infections**		
Post-Menopausal			**Vision or Eye Problems**		
Prostate Problems			**Vomiting Blood**		
Psychiatric Care			**Other:**		

SOCIAL HISTORY

Occupation					**Notes**	
Education					**Notes**	
Able to Care for self?	Yes		No		**Notes**	
Alcohol intake	None	Occ	Mod	Heavy	**Yrs of use:**	
Special Diet (eg: vegan)					**Notes**	
Exercise level	None	Occ	Mod	Heavy	**Notes**	
Caffeine intake	None	Occ	Mod	Heavy	**Notes**	
DNR in place	Yes	No			**Notes**	
Live alone or with others					**Notes**	
Illicit Drugs					**Yrs of use:**	
Recreational Drugs/Products					**Yrs of use:**	
Stress level	Low	Med	High		**Notes**	
Sporting Activities					**Notes**	
Sexually active?	Yes		No		**Notes**	
Protective sex?	Yes		No		**Notes**	
Past History of Abuse	Yes		No		**Notes**	
Current Abuse	Yes		No		**Notes**	
Type of Abuse	Verbal		Physical	Emotional	**Notes**	
Smoking Status/ Vaping chewing tobacco	Never	Former	Current Daily	Current Sporadic	**Yrs of use:**	How much:

Name: ____ **Date of Birth:** __________________

Date of Last Flu Shot: ______________________________

Date of Last Pneumonia Vaccine: ____________________

Colon Cancer Screening: Y☐ ☐ **Date Screened:** ______________________________

Screen Type:

☐ **Colonoscopy** ☐ **Flexible Sigmoidoscopy** ☐ **Fecal Occult Blood Testing**

Any Polyps or Biopsies done: Ye☐ N☐ **Specify:** ____

Abnormal Findings: ____

Do you have allergies to any of the following:

☐ **Latex**

☐ **Iodine, when:** ____

☐ **IV Contrast, when:** ____

☐ **Adhesives, type:** ____

☐ **No known Allergies**

Name: ____ DOB: _____________________

REVIEW OF SYSTEMS

Please check if you are currently having or have had a history of the following:

CONSTITUTIONAL

____ Excess Weight Loss
____ Excess Weight Gain
____ Fever
____ Exercise Intolerance
____ Night Sweats

ENT and EYES

____ Sore Throat
____ Snoring
____ Sinus Problems
____ Hearing Loss
____ Ear Pain
____ Nose Bleeding
____ Vision Changes
____ Dry Eyes

CARDIOVASCULAR

____ Chest Pain
____ Arm Pain w/exertion
____ Shortness of breath w/walking
____ Shortness of breath w/lying down
____ Palpitations
____ Heart Murmur

RESPIRATORY

____ Cough
____ Wheezing
____ Shortness of Breath
____ Coughing up Blood

GASTROINTESTINAL

____ Change in Appetite
____ Heartburn
____ Nausea
____ Vomiting
____ Constipation
____ Diarrhea
____ Blood in Stool
____ Abdominal Pain
____ Ulcers

GENITOURINARY

____ Incontinence
____ Blood in Urine
____ Frequency
____ Difficulty Urinating

MUSCULOSKELETAL

____ Swelling in Extremities
____ Back Pain
____ Joint Pain
____ Muscle Weakness
____ Muscle Aches

SKIN

____ Rashes
____ Abnormal Moles
____ Itching
____ Dry Skin
____ Jaundice

NEUROLOGICAL

____ Fainting
____ Muscle Weakness
____ Numbness
____ Headaches
____ Stroke
____ Dizziness
____ Seizures

PSYCHIATRIC

____ Depression
____ Sleep Disturbance
____ Feel Unsafe
____ Alcohol Abuse
____ Anxiety

ENDOCRINE

____ Fatigue

HEMATOLOGIC

____ Bruise Easily
____ Swollen Glands
____ History of Blood Clots

ALLERGIC

____ Runny Nose
____ Sinus Pressure
____ Itching
____ Hives
____ Frequent Sneezing

OTHER: (please list)

____ Steroid Use
____ Asthma
____ Heart Attack
____ High Blood Pressure
____ Thyroid Disease
____ Anemia

____

____

____

____