

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Your Health History**

Do you have a history of:

|                        | Yes                      | No                       |
|------------------------|--------------------------|--------------------------|
| Cancer                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes               | <input type="checkbox"/> | <input type="checkbox"/> |
| Phlebitis/Blood Clots  | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures               | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding disorders     | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart trouble          | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney trouble         | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver trouble          | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid trouble        | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung trouble           | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood pressure trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis              | <input type="checkbox"/> | <input type="checkbox"/> |
| Gout                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis           | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach ulcers         | <input type="checkbox"/> | <input type="checkbox"/> |
| Other illnesses        | <input type="checkbox"/> | <input type="checkbox"/> |

Please explain any YES answers:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Your Prior Surgeries**

(Please list with dates)

None

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Your Current Medications**

(Please list names & dosages)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies**

(Please list names & reactions)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Your Family History**

Does anyone in your immediate family have any of these?

|                               | Yes                      | No                       |
|-------------------------------|--------------------------|--------------------------|
| Heart disease                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood pressure trouble        | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding disorders            | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood clots (legs/lungs)      | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney trouble                | <input type="checkbox"/> | <input type="checkbox"/> |
| Complications from anesthesia | <input type="checkbox"/> | <input type="checkbox"/> |

Did anyone in your *immediate* family die before the age of 45? Y / N

If so, please list age, relation, & cause.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Social History**

Most recent occupation:

\_\_\_\_\_

Married    Single    Widowed

Number of pregnancies \_\_\_\_\_ N/A \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How long? \_\_\_\_\_

How many packs a day? \_\_\_\_\_

When did you quit? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_

If so, how often? \_\_\_\_\_

**Review of Systems**

Have you recently had or do have any of these symptoms?

No to all

|                         | Yes                      | No                       |
|-------------------------|--------------------------|--------------------------|
| Fevers                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Shaking chills          | <input type="checkbox"/> | <input type="checkbox"/> |
| Sudden weight loss      | <input type="checkbox"/> | <input type="checkbox"/> |
| Incontinence            | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain              | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in vision        | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of hearing         | <input type="checkbox"/> | <input type="checkbox"/> |
| Nose bleeds             | <input type="checkbox"/> | <input type="checkbox"/> |
| Toothache               | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding gums           | <input type="checkbox"/> | <input type="checkbox"/> |
| Morning cough           | <input type="checkbox"/> | <input type="checkbox"/> |
| Coughing up blood       | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty swallowing   | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach pain            | <input type="checkbox"/> | <input type="checkbox"/> |
| Nausea or vomiting      | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood in stool          | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood in urine          | <input type="checkbox"/> | <input type="checkbox"/> |
| Black or tarry stool    | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent diarrhea       | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent constipation   | <input type="checkbox"/> | <input type="checkbox"/> |
| Bladder control trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Bowel control trouble   | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning while urinating | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent headaches      | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath     | <input type="checkbox"/> | <input type="checkbox"/> |

**Women:**

|                   |                          |                          |
|-------------------|--------------------------|--------------------------|
| Irregular periods | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent spotting | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you nursing?  | <input type="checkbox"/> | <input type="checkbox"/> |

Anything else you would like us to know about your history?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician Signature

Date