

Please list the physicians that have treated you previously for this problem:

Physician: _____ Specialty: _____ Phone: _____

Physician: _____ Specialty: _____ Phone: _____

Have you ever had any problems with Anesthesia? Yes / No _____

Have you ever had any complications from prior surgery? Yes / No _____

MEDICAL & FAMILY HISTORY

Please select any past medical conditions and list any family members (mother, father, etc.) below:

Condition	You	Family Member	Condition	You	Family Member
Anxiety	Yes		Lung Disease	Yes	
Anemia	Yes		Lyme Disease	Yes	
Arrhythmia (Irregular heartbeat)	Yes		Neurologic Disorders	Yes	
Asthma	Yes		Osteoarthritis	Yes	
Bleeding Problems	Yes		Osteoporosis	Yes	
Blood Clots (DVT)	Yes		Peripheral Vascular Disease	Yes	
Cancer	Yes		Pneumonia	Yes	
Diabetes	Yes		Psychiatric Illness	Yes	
Gout	Yes		Pulmonary Embolus	Yes	
Heart Attack	Yes		Reflex Sympathetic Dystrophy	Yes	
Heart Disease	Yes		Reflux / Gastric Ulcers	Yes	
High Blood Pressure	Yes		Rheumatologic Disorder	Yes	
High Cholesterol	Yes		Seizure Disorders	Yes	
Hepatitis	Yes		Sleep Apnea	Yes	
Immune Disorders	Yes		Stroke / TIA	Yes	
Infections	Yes		Open Wounds/Ulcers	Yes	
Kidney Disorders	Yes		Other:	Yes	

SURGICAL & HOSPITALIZATION HISTORY

Previous Operation/Hospitalization	Occurrence Date (approx.)
1.	
2.	
3.	
4.	
5.	
6.	

ALLERGY	REACTION
1.	
2.	
3.	
4.	
5.	

MEDICATIONS	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

REVIEW OF SYSTEMS

Are you currently having, or have you had problems in the past year with (select all that apply):

Constitutional	ENT	Eyes	Respiratory
Weight Change	Congestion	Dryness	Chest tightness
Appetite Change	Ear pain	Discharge	Choking
Chills	Nosebleeds	Itching	Cough
Fatigue	Sinus pressure	Pain	Shortness of breath
Fever	Sore throat	Redness	Wheezing
None	None	None	None

Cardiovascular	Gastrointestinal	Endocrine	Genitourinary
Chest pain	Abdominal pain	Cold intolerance	Difficult urination
Leg swelling	Blood in stool	Heat intolerance	Flank pain
Palpitations	Constipation	Excessive thirst	Frequent urination
Poor circulation	Heartburn	Excessive hunger	Painful urination
	Nausea		
None	None	None	None

Musculoskeletal	Skin	Environmental Allergies	Neurological
Joint pain	Color change	Pollen	Dizziness
Joint stiffness	Hair loss	Dust Mites	Headaches
Joint swelling	Rash	Pets/Animals	Light-headedness
Joint warmth/heat	Skin tightening	Mold/Mildew	Memory loss
Muscle pain	Wound		Numbness
			Weakness
None	None	None	None

Hematologic	Psychiatric	Other
Enlarged lymph nodes	Agitation	
Bruises	Hyperactive	
Clotting problem	Nervous/anxious	
Excessive bleeding	Depression	
None	None	

SOCIAL HISTORY

- 1. Are you a tobacco user? Yes / No How Much / Often _____
- 2. Do you consume alcohol? Yes / No How Much / Often _____
- 3. Do you consume caffeine? Yes / No How Much / Often _____
- 4. Do you use recreational drugs? Yes / No How Much / Often _____
- 5. Have you had a Flu vaccine this year? Yes / No When _____
- 6. Have you had a Pneumovax vaccine this year? Yes / No When _____
- 7. Do you have a history of falls? Yes / No How Often _____

For Females Only: Gynecological History

Do you think you may be pregnant at this time?	Yes No	Date:
Do you use birth control?	Yes No	Type:
Have you experienced menopause?	Yes No	When:
Last pap smear:	Date:	
Last mammogram:	Date:	

PLEASE PROVIDE YOUR PHARMACY INFORMATION:

Pharmacy Name & Address _____
Pharmacy Phone #: _____