



PATIENT MEDICAL HISTORY

Date _____

Chart # _____

PCP _____

Ref Physician _____

Patient's Name _____

Date of Birth _____ Age _____ Weight _____ Height _____ Date of last tetanus _____

Problems with Anesthesia? YES NO If yes, explain _____

Current Complaints _____

Allergies/Difficulty with Medication	Reaction <input type="checkbox"/> None	Current Medication	How Taken <input type="checkbox"/> None
1. _____		1. _____	_____
2. _____		2. _____	_____
3. _____		3. _____	_____
4. _____		4. _____	_____
5. _____		5. _____	_____

Please Check All That Apply To You:

PERSONAL INFORMATION			
<input type="checkbox"/> No Illnesses	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Bladder/Kidney Infection	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bleeding Disorders
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Attack or Heart Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Intestinal Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Mental or Nervous Disorder	<input type="checkbox"/> Angina
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Heart Murmurs/Valve Problems
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Other
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Specify _____

SOCIAL HISTORY	
Do you smoke cigarettes?	<input type="checkbox"/> YES <input type="checkbox"/> NO How many packs per day? _____
Do you drink alcohol?	<input type="checkbox"/> YES <input type="checkbox"/> NO Number of drinks per day _____ per week _____
Do you take drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO Check all that apply: <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> Others (specify) _____
Marital Status:	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Number of Children _____
Are you:	<input type="checkbox"/> Right Handed <input type="checkbox"/> Left Handed
Employment: (Type)	_____

FAMILY HISTORY (Siblings, parents and children)	REVIEW DATE
<input type="checkbox"/> No Diseases	Date Initial
<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Excessive Bleeding	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Problems with Anesthesia	_____
<input type="checkbox"/> Tuberculosis	_____

Physician's Signature _____

Previous Surgery None

Dates

1. _____
2. _____
3. _____
4. _____
5. _____

RECENT DIAGNOSTIC TESTS (Please check all that apply within the last 3-6 months): None

Chest X-ray Stress Test Blood Work EKG

REVIEW OF SYMPTOMS (Please check all that apply within the last 3-6 months)

<p>GENERAL: <input type="checkbox"/> None</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Night Sweats</p> <p><input type="checkbox"/> Weight Change</p> <p>ABDOMEN: <input type="checkbox"/> None</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Pain and/or Difficulty Swallowing</p> <p><input type="checkbox"/> Gas</p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Abdominal Pain</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Blood Stools</p> <p>MUSCULOSKELETAL: <input type="checkbox"/> None</p> <p><input type="checkbox"/> Fracture</p> <p><input type="checkbox"/> Sprain</p> <p><input type="checkbox"/> Strains</p> <p><input type="checkbox"/> Dislocations</p>	<p>HEAD: <input type="checkbox"/> None</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Blackouts</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Hearing Loss</p> <p><input type="checkbox"/> Double and/or Blurred Vision</p> <p><input type="checkbox"/> Ringing in Ears</p> <p><input type="checkbox"/> Sinusitis</p> <p><input type="checkbox"/> Post Nasal Drip</p> <p><input type="checkbox"/> Sore Throat</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Cold</p> <p>URINARY: <input type="checkbox"/> None</p> <p><input type="checkbox"/> Blood in Urine</p> <p><input type="checkbox"/> Burning with Urination</p> <p><input type="checkbox"/> Bladder or Kidney Infections</p> <p><input type="checkbox"/> Frequency and/or Difficulty with Starting Urination</p> <p><input type="checkbox"/> Sense of Full Bladder</p> <p><input type="checkbox"/> Difficulty with Leaking Urine</p> <p><input type="checkbox"/> Getting Up at Night to Urinate</p> <p>SKIN: <input type="checkbox"/> None</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> Change in or Bleeding of Mole</p>	<p>CHEST: <input type="checkbox"/> None</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Cold</p> <p><input type="checkbox"/> Sputum</p> <p><input type="checkbox"/> Coughing up Blood</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Shortness of Breath</p> <p><input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Heart Murmur</p> <p><input type="checkbox"/> Swelling of Feet</p> <p><input type="checkbox"/> Rheumatic Fever</p> <p>NEUROMUSCULAR: <input type="checkbox"/> None</p> <p><input type="checkbox"/> Joint Stiffness</p> <p><input type="checkbox"/> Joint Pain</p> <p><input type="checkbox"/> Swelling</p> <p><input type="checkbox"/> Back Pain</p> <p><input type="checkbox"/> Varicose Veins</p> <p><input type="checkbox"/> Night Cramps</p> <p><input type="checkbox"/> Bursitis</p> <p><input type="checkbox"/> Tendonitis</p> <p><input type="checkbox"/> Raynaud's</p>
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FEMALE PATIENTS

Do you take Birth Control Pills? YES NO

If YES, type _____

Do you take PREMARIN or ESTROGEN or other hormonal replacement? YES NO

If YES, type _____

Is there any chance you are pregnant? YES NO