Patient Name: _____ DOB _____

Ref. Doctor: _____ Date: _____

Social History

Are you: Single ❍ Married ❍ Divorced ❍ Widowed ❍

Living Arrangements: Home alone ❍ Home with Spouse ❍ Assisted Living ❍ Nursing Home ❍

Do you presently smoke tobacco? Yes ❍ No ❍
If yes, please list the amount you smoke: _____Packs/week _____Number of years smoked
Do you drink alcohol regularly? Yes ❍ No ❍
If yes, please list the amount and type ingested per day: _____

Doctor Notes:

Family History (Do you have a family history of any of the following illnesses?)

Illness	Yes	No	Illness	Yes	No
Cancer			Rheumatoid Arthritis		
Heart Disease			Degenerative Arthritis		
High Blood Pressure			Thyroid Disease		
Diabetes			Immune Disorders		

Review of Systems

	Yes	No		Yes	No		Yes	No
Constitutional Symptoms			**Gastrointestinal**			**Neurological**		
Recent weight change			Loss of appetite			Frequent headaches		
Fever			Nausea or vomiting			Light headed or dizzy		
Unexplained swearing			Frequent diarrhea			Seizures		
Eyes			Constipation			Numbness or tingling		
Wear glasses or contacts			Rectal bleeding or blood in stool			Tremors		
Blurred or double vision			Black tarry stools			Paralysis		
Glaucoma			Regular abdominal pain or heartburn			**Psychiatric**		
ENT			**Genitourinary**			Memory loss or confusion		
Hearing loss			Frequent urination			Anxiety		
Regular nose or gum bleeding			Burning or painful urination			Depression		
Sore throat			Blood in urine			Insomnia		
Swollen glands in neck			Incontinence or dribbling			**Endocrine**		
CV			Female: # of Pregnancies			Glandular or Hormone Problem		
Irregular heart beats			Female: # of miscarriages			Excessive thirst or urination		
Shortness of breath w/ walking or lying flat			**Musculoskeletal**			Heat or cold intolerance		
Swelling in feet, ankles and hands			Joint pain			Changes in hair or nails		
Fainting spells			Joint stiffness and swelling			**Hematology**		
Elevated cholesterol			Morning stiffness			Bruising tendency		
Respiratory			Difficulty walking			Anemia		
Chronic or frequent coughing			Muscle cramping			Need for past transfusion		
Spitting up blood			**Integumentary**					
Regular shortness of breath			Rash or itching			Height: _____		
Emphysema			Changes in skin color			Weight: _____		
Regular wheezing			Varicose veins					
Breast								
Any lumps								
Nipple drainage								
Pain								

I certify that to the best of my knowledge the preceding information is true and accurate.

_____

Patient Signature (or parent if patient is a minor)

Doctor Notes:
I certify that I have reviewed and updated the information on this form.

Initial	Date	Initial	Date	Initial	Date	Initial	Date

Past Medical History

Illness/Injury	Yes	No	Illness/Injury	Yes	No
High blood pressure			Kidney disease		
Diabetes			Liver Disease		
Heart attack			Females ONLY: Are you or could you be pregnant		
Chest pain or angina			AIDS or HIV Infection		
Stroke			Thyroid problems		
Cancer			Shortness of breath		
Hepatitis			Blood clots		
Stomach Ulcers			Bleeding tendency		
Arthritis			Accidents / Broken bones (please list)		
Gout					
Anesthetic complications					

Past Surgical History

Year	Name of Operation	Type of Anesthetic (general, regional, local)	Complications

Medications

Drug	Dosage	Drug	Dosage
1.		2.	
3.		4.	
5.		6.	
7.		8.	
9.		10.	

Do you take diet pills or nutritional supplements? Yes ❍ No ❍
If yes, please list the type and when last taken:

Name	Date Last Taken
1.	
2.	

Allergies

Do you have a history of latex allergy? Yes ❍ No ❍

Drug	Dosage	Drug	Dosage
1.		2.	
3.		4.	

Immunization History

When was your last tetanus shot?