



Patient Name: _____ Date: _____
 Date of Birth: _____ SS#: _____
 Referring Physician: _____ Advance Directives: Y N
 Allergies: Y N Living Will: Y N

SURGICAL HISTORY

Year _____ Surgery _____
 Year _____ Surgery _____
 Year _____ Surgery _____
 Year _____ Surgery _____
 Year _____ Surgery _____
 Year _____ Surgery _____

MEDICAL HISTORY

Do you have a history of:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes:	_____	
High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Location:	_____	
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Duration:	_____	
Heart Oproblems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	On a scale of 1 to 10 with 10 being the worst:	_____	
Arthritis/Gout	Yes <input type="checkbox"/>	No <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10	_____	
Convulsions	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Medications taken for pain:	_____	
Bleeding tendency	Yes <input type="checkbox"/>	No <input type="checkbox"/>		_____	
Veneral Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>		_____	
Heredity Defects	Yes <input type="checkbox"/>	No <input type="checkbox"/>		_____	
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>		_____	



PATIENT SOCIAL HISTORY

Marital Status S M W S D

Use of Alcohol: Never Rarely Moderate Daily

Use of tobacco: Never Previously but quit _____ Years _____

currently smokes Packs per day _____ Years _____

Use of drugs: Never Type/Frequency: _____

Excessive exposure at home or work to:

Airborn particles Dust Fumes Solvents

Other: _____

MEDICAL HISTORY

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

HOSPITALIZATIONS

Year _____ Reason _____

Year _____ Reason _____

Year _____ Reason _____

Year _____ Reason _____



SYSTEM REVIEW

Please check **YES** or **NO** to the following

Constitutional Symptoms

- Recent weight change Yes No
- Fever Yes No
- Fatigue Yes No
- Headaches Yes No

Eyes

- Eye disease/injury Yes No
- Wear glasses/contacts Yes No
- Blurred or double vision Yes No
- Glaucoma Yes No

Ears/Nose/Mouth/Throat

- Earaches/drainage Yes No
- Chronic sinus problems Yes No
- Nose bleeds Yes No
- Mouth sores Yes No
- Bleeding gums Yes No
- Sore throat/voice change Yes No
- Swollen gland in neck Yes No

Cardiovascular

- Heart trouble Yes No
- Chest pain Yes No
- Palpitations Yes No
- Shortness of breath Yes No
- Swelling of feet & ankles Yes No
- Varicose veins Yes No

Respiratory

- Chronic or frequent coughs Yes No
- Spitting up blood Yes No
- Shortness of breath Yes No
- Asthma or wheezing Yes No

Gastrointestinal

- Loss of appetite Yes No
- Change in bowel movements Yes No
- Nausea or vomiting Yes No
- Frequent diarrhea Yes No
- painful bowel movements Yes No
- Constipation Yes No
- Blood in stool/bleeding Yes No
- Abdominal pain Yes No
- Heartburn Yes No
- Ulcers Yes No

Genitourinary

- Frequent urination Yes No
- Burning/painful urination Yes No
- Blood in urine Yes No
- Incontinence or dribbling Yes No
- Kidney stones Yes No
- Male-testicle pain Yes No
- Females

Menstrual history:

Age of onset: _____
 Regular Irregular

Length of Cycle: _____

SYSTEM REVIEW (CONTINUED)

Genitourinary (Continued)

Number of pregnancies _____
 Number of Live births _____
 Number of miscarriages _____
 Last pap smear _____
 Last mammogram _____
 Menopause Yes No
 if yes, age of onset _____

Please check **YES** or **No** to the following:

Musculoskeletal

Joint pain Yes No
 Joint stiffness/swelling Yes No
 Muscle pain/cramps Yes No
 Back pain Yes No
 Cold extremities Yes No
 Difficulty in walking Yes No
 Bone fractures/injuries Yes No

Skin/Breast

Rash or itching Yes No
 Change in skin color Yes No
 Change in hair or nails Yes No
 Breast lump/pain/discharge Yes No

Neurological

Frequent or recurring heads Yes No
 Light headed or dizzy Yes No
 Convulsions/seizures Yes No
 Numbness or tingling Yes No

Neurological (continued)

Tremors Yes No
 Paralysis Yes No
 Stroke Yes No
 Head injury Yes No
 Yes No

Psychiatric

Memory loss/ confusion Yes No
 Nervousness Yes No
 Depression Yes No
 Insomnia Yes No
 Mental illness Yes No

Endocrine

Hormone problems Yes No
 Thyroid disease Yes No
 Excessive thirst Yes No
 Excessive urination Yes No
 Heat/cold intolerance Yes No

Hematological

Slow to heal after cuts Yes No
 Bleeding or bruising Yes No
 Anemia Yes No
 Phlebitis Yes No
 Past transfusions Yes No
 Enlarged glands Yes No

Allergic

History of skin reactions to: Yes No
 Penicillin or antiotics Yes No
 Moripine or Demoral Yes No
 Novacaine/anesthetics Yes No

Other Drugs: _____

Food allergies _____