Name _____ Date of Birth _____

Your Health History

Do you have a history of:

	Yes	No
Cancer	____	____
Diabetes	____	____
Blood Clots	____	____
Seizures	____	____
Bleeding disorders	____	____
Heart trouble	____	____
Kidney trouble	____	____
Liver trouble	____	____
Thyroid trouble	____	____
Lung trouble	____	____
Stroke	____	____
Blood pressure	____	____
Arthritis	____	____
Gout	____	____
Osteoporosis	____	____
Anemia	____	____
Stomach ulcers	____	____

Other illnesses_____

Please explain any YES answers:

_____
_____
_____
_____
_____
_____

Your Prior Surgeries

(Please list with dates)

[ ] None

_____
_____
_____
_____
_____
_____

Your Current Medications

(Please list names & dosages)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Medication Allergies

(Please list names & reactions)

_____
_____
_____
_____
_____
_____
_____

Your Family History

Does anyone in your immediate family have any of these?

	Mom / Dad
Heart disease	____ ____
Blood pressure trouble	____ ____
Bleeding disorders	____ ____
Cancer	____ ____
Blood clots (legs/lungs)	____ ____
Diabetes	____ ____
Kidney trouble	____ ____
Complications from anesthesia	____ ____

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

Are you currently experiencing any of these symptoms today?

[ ] **No to all**

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

Pain Level: (Please circle)

No Pain 1 2 3 4 5 6 7 8 9 10

Women:	Yes / No
Irregular periods	____ ____
Frequent spotting	____ ____
Are you pregnant?	____ ____
Are you nursing?	____ ____
Last menstrual period?	_____

Reason for your visit today? (Briefly Explain)

_____
_____
_____
_____
_____
_____
_____
_____