Name _____ Date of Birth _____ SSN _____
Height_____ Weight_____

Reason for Being Seen:_____

Allergies and Reactions: _____

Current Medications (May continue on back)

Drug Name Dose Frequency

_____
_____
_____
_____
_____
_____
_____

Medical History (circle all that apply to you)

Allergies	Deep Vein Thrombosis	Nerve/Muscle Disease
Anemia	Depression	Osteoporosis
Anesthesia Problems	Diabetes Mellitus	Pulmonary Embolism
Anxiety	Emphysema	Seizures
Arthritis	GERD	Sickle Cell Anemia
Asthma	Glaucoma	Sleep Apnea
Autoimmune Disease	Heart Attack	Stroke
Back Problems	Heart Murmur	Substance Abuse
Blood Transfusion	Heart Rhythm Problem	Thyroid Disease
Bowel Problems	Hearing Loss	Tuberculosis
Cancer (Type)_____	HIV/AIDS	Ulcers
Cataracts	Hypertension	Urinary Problems
Congestive Heart Failure	Inflammatory Bowel Disease	H/O Resistant Bacterial Infection (i.e. MRSA)
Clotting Disorder	Kidney Disease	
COPD	Liver Disease	Other_____
Coronary Artery Disease	Meningitis	_____
		_____

Surgical History (Please mark all that apply to you. Give year and type.)

Appendectomy_____	Hernia Surgery_____
Brain Surgery_____	Hysterectomy/GNY Surgery_____
Breast Surgery_____	Joint Replacement_____
Heart Bypass/Stent_____	Pacemaker/Defibrillator_____
Gallbladder Surgery_____	Port Placement_____
Colon/Bowel Surgery_____	Neck Surgery_____
Cosmetic Surgery_____	Spine Surgery_____
C-section_____	Tubal Ligation/Vasectomy_____
Eye Surgery_____	Abdominal Surgery _____
Heart Surgery_____	Other_____

Social History

Do you smoke yes no How many packs per day _____ How long _____ Quit Date _____	Do you use smokeless tobacco yes no Quit Date _____ Do you use any drugs _____ Do you drink _____

Family History

Has any blood relative ever had:
Please Circle Yes or No and Write Who:

Allergy (severe) Yes No _____ Alzheimer's Disease Yes No _____ Anesth. Problems Yes No _____ Angioedema Yes No _____ Arrhythmia Yes No _____ Arthritis Yes No _____ Asthma Yes No _____ Bleeding Problems Yes No _____ BRCA ½ Yes No _____ Cancer Yes No _____ Type _____ _____ Celiac Disease Yes No _____ Chdhd hrt surg Yes No _____ Colon Polyps Yes No _____ COPD Yes No _____ Coronary Art. Dis. Yes No _____ Clotting Disorder Yes No _____ Diabetes Yes No _____ Heart Attack Yes No _____ Heart Defect Yes No _____	Heart Disease Yes No _____ Heart Failure Yes No _____ Heart Surgery Yes No _____ High Blood Press Yes No _____ High Cholesterol Yes No _____ Hip Fracture Yes No _____ Inflam. Bowel Dis. Yes No _____ Irritable Bowl Yes No _____ Kidney Disease Yes No _____ Liver Disease Yes No _____ Lou Gehrig's Dis. Yes No _____ Lupus Yes No _____ Osteoporosis Yes No _____ Rheum. Arthritis Yes No _____ Seizures Yes No _____ Sickle Cell Trait Yes No _____ Stroke Yes No _____ Sudden death Yes No _____ Thyroid Disease Yes No _____ Ulcerative Colitis Yes No _____

Other

_____
_____
_____
_____
_____
_____
_____
_____

Current Symptoms

_____
_____
_____
_____
_____
_____
_____