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Section 1: PAST MEDICAL HISTORY

Description of past/present injury, illness, surgery or hospitalization	If surgery or hospitalization: Provide name of physician & facility	Approximate Date

Have you ever experienced problems with anesthesia? ___ Yes ___ No
If yes, please explain: _____

Do you have any known allergies? ___ Yes ___ No *If yes, please list:*
Environmental: _____, Food: _____,
Medication allergies: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION	DOSAGE	FREQUENCY

Section II. FAMILY HISTORY

Please complete by identifying with an X if the relative is living or deceased:

Family Member	Living	Age	Deceased	Age at death	Health status/Cause of death
MOTHER					
FATHER					
GRANDMOTHER (Mom's)					
GRANDFATHER (Mom's)					
GRANDMOTHER (Dad's)					
GRANDFATHER (Dad's)					
BROTHER/SISTER **(Circle one)**					
BROTHER/SISTER **(Circle one)**					
BROTHER/SISTER **(Circle one)**					

Section III. SOCIAL HISTORY

1. Are you currently working? Full time □ Part-time□ Disabled□ Retired (when) _____

2. Current/previous occupation: _____For how long? _____

3. Have you ever been pregnant? □ No □ Yes Contraceptive method _____
# of pregnancies _____ # of abortions _____ # of miscarriages _____

4. Use of Tobacco: □ No, I've never smoked or used smokeless tobacco products (E.g. snuff, chew, etc.)
□ No, I previously used, but have quit using smokeless tobacco products.
□ No, I quit smoking___ years ago
(At that time I smoked ___ packs per day for ___ years).
□ Yes, I smoke cigars/pipe.
□ Yes, I use smokeless tobacco products.
□ Yes, I smoke cigarettes occasionally, but not daily.
□ Yes, I've smoked ___ packs of cigarettes per day for ___ years.

5. Alcohol consumption:
□ None; never (or rarely).
□ No, but I have previously.
□ Yes, 1 or more times per month.
□ Yes, 1 or more times per week.
□ Yes, daily.

6. Illegal drug use: □ No □ No, but I have previously. Type/frequency _____

□ Yes, presently. Type/frequency _____

7. Are you at risk for AIDS? (E.g. sexually active, sexual orientation, drug abuse, previous blood transfusion)

□ No □ Yes (please explain): _____

8. Caffeine intake: _____ per day Source: _____

9. Do you exercise? □ No □ Yes (type/frequency): _____

10. Do you take antacids more than three (3) times a week: □ No □ Yes

11. Have you been outside of the U.S. within the last 12 month: □ No □ Yes
If yes, where have your traveled? _____

IV. REVIEW OF SYSTEMS

Are you currently having, or have you ever had problems with (please complete each item):

CONSTITUTIONAL

Fever: □ Never □ Currently □ In the past
Weight loss: □ Never □ Currently □ In the past
Excessive fatigue: □ Never □ Currently □ In the past
Night sweats: □ Never □ Currently □ In the past

EYES

Wear glasses: □ Never □ Currently □ In the past
Wear contacts: □ Never □ Currently □ In the past
Date of last eye exam: _____
Eye infections: □ Never □ Currently □ In the past
Eye injury: □ Never □ Currently □ In the past
Glaucoma: □ Never □ Currently □ In the past
Cataracts: □ Never □ Currently □ In the past

EARS, NOSE, MOUTH & THROAT

Hearing aid: □ Never □ Currently □ In the past
Date of last hearing exam: _____
Hearing loss: □ Never □ Currently □ In the past
Ear pain: □ Never □ Currently □ In the past
Ear infections: □ Never □ Currently □ In the past
Ringing in ears: □ Never □ Currently □ In the past
(If ringing, check) □ Both □ Left □ Right
Balance problems: □ Never □ Currently □ In the past
Nosebleeds: □ Never □ Currently □ In the past
Nasal congestion: □ Never □ Currently □ In the past
Nasal drainage: □ Never □ Currently □ In the past
Sinus infections: □ Never □ Currently □ In the past
Sinus headaches: □ Never □ Currently □ In the past
Sore throat: □ Never □ Currently □ In the past
Mouth sores: □ Never □ Currently □ In the past

CARDIOVASCULAR

Chest pain: □ Never □ Currently □ In the past
EKG: □ Never □ Date of last: _____
High blood press: □ Never □ Currently □ In the past
Irregular pulse: □ Never □ Currently □ In the past
Heart murmur: □ Never □ Currently □ In the past
High cholesterol: □ Never □ Currently □ In the past

RESPIRATORY

Asthma: □ Never □ Currently □ In the past
Chronic cough: □ Never □ Currently □ In the past
Emphysema: □ Never □ Currently □ In the past
Shortness of breath: □ Never □ Currently □ In the past
Bronchitis: □ Never □ Currently □ In the past
Pneumonia: □ Never □ Currently □ In the past
Lung cancer: □ Never □ Currently □ In the past
Bloody sputum: □ Never □ Currently □ In the past
Chest X-ray □ Never □ Date of last:_____

GASTROINTESTINAL

Indigestion: □ Never □ Currently □ In the past
Nausea: □ Never □ Currently □ In the past
Vomiting: □ Never □ Currently □ In the past
Blood in vomit: □ Never □ Currently □ In the past
Liver disease: □ Never □ Currently □ In the past
Jaundice: □ Never □ Currently □ In the past:
Abdominal pain: □ Never □ Currently □ In the past:
Change in bowel habits: □ Never □ Currently □ In the past
Ulcers/Gastritis: □ Never □ Currently □ In the past
Colon cancer: □ Never □ Currently □ In the past

IV. REVIEW OF SYSTEMS - Continued

GENITOURINARY

Urinary tract infect: ☐ Never ☐ Currently ☐ In the past
Painful urination: ☐ Never ☐ Currently ☐ In the past
Blood in urine: ☐ Never ☐ Currently ☐ In the past
Difficulty urinating: ☐ Never ☐ Currently ☐ In the past
Incontinence: ☐ Never ☐ Currently ☐ In the past
Kidney stones: ☐ Never ☐ Currently ☐ In the past
Prostate cancer: ☐ Never ☐ Currently ☐ In the past
Endometriosis: ☐ Never ☐ Currently ☐ In the past
Uterine cancer: ☐ Never ☐ Currently ☐ In the past
Cervical cancer: ☐ Never ☐ Currently ☐ In the past

MUSCULOSKELETAL

Broken bones: ☐ Never ☐ Currently ☐ In the past
(List with dates): _____
Arm/leg weakness: ☐ Never ☐ Currently ☐ In the past
Back pain: ☐ Never ☐ Currently ☐ In the past
Joint pain: ☐ Never ☐ Currently ☐ In the past
Joint swelling: ☐ Never ☐ Currently ☐ In the past
Arthritis: ☐ Never ☐ Currently ☐ In the past

INTEGUMENTARY

Skin disease: ☐ Never ☐ Currently ☐ In the past
Skin cancer: ☐ Never ☐ Currently ☐ In the past
Breast pain: ☐ Never ☐ Currently ☐ In the past
Breast swelling: ☐ Never ☐ Currently ☐ In the past
Nipple discharge: ☐ Never ☐ Currently ☐ In the past
Mammogram: ☐ Never ☐ Date of last results:_____

ALLERGIC/IMMUNOLOGIC

Food allergies: ☐ Never ☐ Currently ☐ In the past
Nasal allergies: ☐ Never ☐ Currently ☐ In the past
Immunologic disorders: ☐ Never ☐ Currently ☐ In the past

NEUROLOGICAL

Fainting or blacking out: ☐ Never ☐ Currently ☐ In the past
Seizures: ☐ Never ☐ Currently ☐ In the past
Memory problems: ☐ Never ☐ Currently ☐ In the past
Disorientation: ☐ Never ☐ Currently ☐ In the past
Speech difficulties: ☐ Never ☐ Currently ☐ In the past
Inability to concentrate: ☐ Never ☐ Currently ☐ In the past
Double or blurred vision: ☐ Never ☐ Currently ☐ In the past
Weakness of face: ☐ Never ☐ Currently ☐ In the past
Coordination problems: ☐ Never ☐ Currently ☐ In the past

PSYCHIATRIC

Anxiety: ☐ Never ☐ Currently ☐ In the past
Depression: ☐ Never ☐ Currently ☐ In the past
Schizophrenia: ☐ Never ☐ Currently ☐ In the past
Manic depressive: ☐ Never ☐ Currently ☐ In the past
Other: _____

ENDOCRINE

Diabetes: ☐ Never ☐ Currently ☐ In the past
Thyroid disease: ☐ Never ☐ Currently ☐ In the past
Increased appetite: ☐ Never ☐ Currently ☐ In the past
Excessive urination: ☐ Never ☐ Currently ☐ In the past
Excessive thirst: ☐ Never ☐ Currently ☐ In the past
Hormone problems: ☐ Never ☐ Currently ☐ In the past

HEMATOLOGIC/LYMPHATIC

Anemia: ☐ Never ☐ Currently ☐ In the past
Hemophilia: ☐ Never ☐ Currently ☐ In the past
Bleeding tendencies: ☐ Never ☐ Currently ☐ In the past
Persistent swollen glands: ☐ Never ☐ Currently ☐ In the past
Blood transfusion: ☐ Never ☐ Yes, Date(s): _____