

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_

Have you been under the care of a medical doctor? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please list name(s) \_\_\_\_\_

***Present Illness***

What is the reason for your visit? \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

***Past Medical History***

Please indicate if you have any of the following:

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Hypertension

\_\_\_\_\_ Emphysema/COPD

\_\_\_\_\_ High Cholesterol

Do you have or have you had any disease, condition or problem not listed above? Include any hospitalizations.

No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

***Past Surgical History***

Have you ever had any procedures or surgeries? Please list them below and the approximate year in which each took place.

| <b>Procedure/Surgery</b> | <b>Year</b> |
|--------------------------|-------------|
|                          |             |
|                          |             |
|                          |             |
|                          |             |
|                          |             |
|                          |             |
|                          |             |

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Family History**

Please indicate if anyone in your family has any of the following:

|                | <b>Mother</b> | <b>Father</b> |
|----------------|---------------|---------------|
| Heart Disease  |               |               |
| Diabetes       |               |               |
| Hypertension   |               |               |
| Emphysema/COPD |               |               |
| Other:         |               |               |

**Social History**

What is your marital status? Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Are you currently or have you ever been a smoker? No \_\_\_\_\_ Yes \_\_\_\_\_

*If no, go to the following section.*

Do you still smoke? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, how many packs per day? \_\_\_\_\_ For how many years? \_\_\_\_\_

If no, when did you quit? \_\_\_\_\_ Prior to quitting, how many packs per day? \_\_\_\_\_

Do you drink alcohol? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, number of drinks per week \_\_\_\_\_

Do you use illicit drugs? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, how frequently? \_\_\_\_\_

Are you currently employed? No \_\_\_\_\_ Yes \_\_\_\_\_

Present or past occupation/employer: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Allergies**

Please list any allergies you have below.

| <b>Medication Allergies</b> | <b>Other Allergies</b> |
|-----------------------------|------------------------|
|                             |                        |
|                             |                        |
|                             |                        |
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|                             |                        |
|                             |                        |

**Medications**

Do you take any prescription or non-prescription drugs? If so, please list the medication, dosage, and how many times per day it is taken.

| <b>Medication</b> | <b>Dosage</b> | <b># Times Taken per Day</b> |
|-------------------|---------------|------------------------------|
|                   |               |                              |
|                   |               |                              |
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|                   |               |                              |

**Review of Systems**

Please indicate if you have recently experienced any of the following:

| Yes | No | CONSTITUTIONAL                    | Yes | No | RESPIRATORY                          |
|-----|----|-----------------------------------|-----|----|--------------------------------------|
|     |    | Fever                             |     |    | Chronic or frequent coughs           |
|     |    | Chills                            |     |    | Spitting up food                     |
|     |    | Weight loss/gain                  |     |    | Wheezing                             |
|     |    | <b>NEUROLOGICAL</b>               |     |    | <b>GASTRO.</b>                       |
|     |    | Frequent or recurring headaches   |     |    | Loss of appetite                     |
|     |    | Light headed or dizzy             |     |    | Change in bowel movements            |
|     |    | Convulsions or seizures           |     |    | Nausea or vomiting                   |
|     |    | Numbness or tingling sensations   |     |    | Frequent diarrhea                    |
|     |    | Tremors                           |     |    | Painful bowel movements/constipation |
|     |    | <b>PSYCHIATRIC</b>                |     |    | Rectal bleeding or blood in stool    |
|     |    | Memory loss or confusion          |     |    | <b>GENITOURINARY</b>                 |
|     |    | Nervousness/Depression            |     |    | Frequent urination                   |
|     |    | <b>EYES</b>                       |     |    | Burning or painful urination         |
|     |    | Eye diseases or injury            |     |    | Blood in urine                       |
|     |    | Wear glasses or contact lenses    |     |    | <b>MUSCULOSKELETAL</b>               |
|     |    | Blurred or double vision          |     |    | Joint pains/stiffness/swelling       |
|     |    | <b>EARS/NOSE/MOUTH/THROAT</b>     |     |    | Weakness of muscles or joints        |
|     |    | Hearing loss or ringing           |     |    | Muscle pain or cramps                |
|     |    | Earaches or drainage              |     |    | Back pain                            |
|     |    | Chronic sinus problem or rhinitis |     |    | Cold extremities                     |
|     |    | Nose bleeds                       |     |    | Difficulty in walking                |
|     |    | <b>CARDIOVASCULAR</b>             |     |    | <b>HEMATOLOGIC/LYMPHATIC</b>         |
|     |    | Heart Trouble                     |     |    | Slow to heal after cuts              |
|     |    | Chest Pain or Angina              |     |    | Bleeding or bruising tendency        |
|     |    | Palpitations                      |     |    | Enlarged glands                      |
|     |    | Shortness of Breath               |     |    | <b>ENDOCRINE</b>                     |
|     |    | Swelling of feet or ankles        |     |    | Excessive thirst or urination        |
|     |    | Rheumatic Fever                   |     |    | Heat or cold intolerance             |
|     |    | Varicose Veins                    |     |    | <b>INTEGUMENTARY (SKIN/BREAST)</b>   |
|     |    | Fainting/Blackouts                |     |    | Rash or itching                      |
|     |    |                                   |     |    | Change in skin color                 |
|     |    |                                   |     |    | Skin disorder                        |

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Surgeon Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_