

Name	DOB	Date
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PAST SURGICAL AND HOSPITAL HISTORY: None Yes, if yes
Please describe your past experience with, **operations**, serious injuries, all and any hospitalizations and related treatments. Please include dates (month/year) of any surgeries.

FAMILY HISTORY

Are there medical events in your family's history, including diseases that may be hereditary or place you at risk?
Please circle **Y** or **N** for each condition (no blanks please ☺)

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
Y	N	High blood pressure	Y	N	Heart disease	Y	N	Thyroid disease
Y	N	Stroke	Y	N	Diabetes	Y	N	Asthma
Y	N	Kidney disease	Y	N	Liver disease	Y	N	Breast disease
Y	N	Cancer (indicate type)						
Y	N	Other						

SOCIAL HISTORY

Marital Status Single Married Widowed Separated Divorced	Drug/Alcohol Use: Yes No Drinks/week	Tobacco Use: Yes No Cigarettes/day
Highest Level of Education	Employment (please include job title)	
Race Caucasian African American Hispanic Asian American Other		

REVIEW OF SYSTEMS

Do you have or have you had any serious or chronic medical conditions?
Please Circle **Y** or **N** or any condition(s) you have had or that you have currently. (no blanks please ☺)

	Yes	No		Yes	No		Yes	No
Constitutional: Weight change	Y	N	Fatigue	Y	N			
Eyes: Vision changes	Y	N	Cataracts	Y	N	Glaucoma	Y	N
Ears/Nose/Mouth/Throat: Ulcers	Y	N	URI	Y	N			
Cardiovascular: Chest pain	Y	N	Orthopnea (difficulty breathing when lying down)	Y	N	DOE (difficulty breathing on exertion)	Y	N
Respiratory: SOB (short of breath)	Y	N	Wheezing	Y	N			
Gastrointestinal: Nausea/Vomiting	Y	N	Diarrhea	Y	N	Bloody Stool	Y	N
Musculoskeletal: Weakness	Y	N						
Integumentary/Skin: Rash	Y	N						
Neurological: Seizure	Y	N	Syncope (fainting)	Y	N	Neuropathy	Y	N
Psychiatric: Depression	Y	N	Anxiety	Y	N			
Endocrine: Hot flashes	Y	N	Diabetes	Y	N	Thyroid	Y	N
Hematologic/Lymphatic: Easy bruising	Y	N	Bleeding	Y	N	Adenopathy (Swollen Glands)	Y	N
Allergic/Immunologic: Seasonal	Y	N	Animal Dander / Foods	Y	N			
Other:								

Patient Signature

Date