Do you currently experience any of the problems or illnesses listed below? If so, please explain.

Constitutional
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Insomnia
- ☐ Weight Gain in Last 3 Months:
  Amount:_____# of Months: _____
- ☐ Weight Loss in Last 3 Months:
  Amount:_____# of Months: _____
- ☐ Other: _________

Eyes
- ☐ Blurred Vision
- ☐ Eye Pain
- ☐ Spots in Vision
- ☐ Vision Loss
- ☐ Double Vision
- ☐ Other: _________

Ears, Nose, Mouth, Throat
- ☐ Ringing in the Ears
- ☐ Vertigo
- ☐ Nose Bleeds
- ☐ Sinus Problems
- ☐ Dental Problems
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Other: _________

Respiratory
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Blood in Phlegm
- ☐ Chest Wall Pain
- ☐ Chemical / Dust Inhalation
- ☐ TB Exposure
- ☐ Valley Fever
- ☐ Histoplasmosis

Respiratory Continued
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Emphysema
- ☐ COPD
- ☐ Asthma
- ☐ Other: _________

Cardiovascular
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Fainting
- ☐ Leg Pain with Walking
- ☐ Leg Swelling
- ☐ Discoloration of Fingers or Toes
- ☐ Varicose Veins
- ☐ Stroke
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Chest Wall Surgery
- ☐ Vena Cava Umbrella or Filter
- ☐ Atrial Fibrillation
- ☐ Pacemaker
  Brand: _________
- ☐ AICD
  Brand: _________
- ☐ Other: _________

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea or Vomiting
- ☐ Reflux/Heartburn
- ☐ Constipation
- ☐ Bloody Stools
- ☐ Stomach Ulcers
- ☐ Jaundice
- ☐ Hep C / Hep B
- ☐ Gallbladder Problems
- ☐ Pancreas Problems
- ☐ Other: _________

Genitourinary
- ☐ Dysuria (Painful urination)
- ☐ Blood in the Urine
- ☐ Incontinence
- ☐ Urinary Frequency
- ☐ Abnormal Vaginal Bleeding
- ☐ Postmenopausal Bleeding
- ☐ Other: _________

Musculoskeletal
- ☐ Pain: Back, Joint, Neck
- ☐ Limited Range of Motion
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Arthritis/Gout
- ☐ Broken Bones
- ☐ Other: _________

Skin
- ☐ Rash
- ☐ Persistent Itch
- ☐ Breast Masses
- ☐ Poor Skin Healing
- ☐ Skin Cancer
- ☐ Other: _________

Neurologic
- ☐ Headache
- ☐ Vision Problems
- ☐ Memory Problems
- ☐ Numbness
- ☐ Poor Balance
- ☐ Weakness
- ☐ Muscle Paralysis
- ☐ Tremor
- ☐ Dizziness
- ☐ Seizures
- ☐ Migraines
- ☐ Other: _________

Psychiatric
- ☐ Anxiety
- ☐ Sleep Disturbances
- ☐ Sadness/Tearfulness
- ☐ Depression
- ☐ PTSD
- ☐ Considered Suicide
- ☐ Generally satisfied with your life
- ☐ Other: _________

Endocrine
- ☐ Cold or Heat Intolerance
- ☐ Tired/Sluggish
- ☐ Diabetes
- ☐ Increased Cholesterol
- ☐ Kidney Disease or Stones
- ☐ Thyroid Disease
- ☐ Other: _________

Hematologic/Lymphatic
- ☐ Bruising
- ☐ Bleeding Tendencies
- ☐ Swollen Glands
- ☐ Blood Clotting Problem
- ☐ Unexplained Bleeding
- ☐ Blood Clots in Veins
- ☐ HIV/AIDS
- ☐ Anemia
- ☐ Other: _________

Allergic/Immunologic
- ☐ Eczema
- ☐ Rheumatic Fever
- ☐ Lupus
- ☐ Vasculitis
- ☐ Sarcoidosis
- ☐ Other: _________

PATIENT MEDICAL HISTORY

THESE QUESTIONS, THOUGH THEY MAY NOT SEEM RELATED TO YOUR PRESENT CONDITION, CAN AND WILL HELP US TAKE BETTER CARE OF YOU WHEN PLANNING ANY NEEDED SURGICAL PROCEDURES. THANK YOU FOR YOUR COOPERATION IN FILLING OUT THIS FORM.

PAST MEDICAL HISTORY: Have you had any of the following operations? Give the date.

C-Section (female) No______Yes______
D & C (how many) No______Yes______
Prostate Surgery(male) No______Yes______
Breast Surgery No______Yes______
Extraction of Teeth No______Yes______
Gallbladder Surgery No______Yes______
KidneySurgery/Disease No______Yes______
Lung Surgery No______Yes______
Skin Surgery/Disease No______Yes______
Tumor Surgery No______Yes______
Other Surgery________________________

Deliveries (how many) No______Yes______
Hysterectomy (female) No______Yes______
Appendectomy No______Yes______
Colon Surgery No______Yes______
Eye Surgery No______Yes______
Heart Surgery No______Yes______
Knee Surgery No______Yes______
Nose Surgery No______Yes______
Tonsils/Adenoids No______Yes______
Cosmetic Surgery No______Yes______

Have you had any complications i.e. unusual bleeding, or scarring following a surgery or injury?______________
Did you have a normal recovery following any previous surgery?______________
Have you ever had any complications with anesthesia during or after surgery?______________
Were the complications resolved?______________
Have you had a mammogram?______Date?________Do you do self breast exams?______How often?________
Have you ever had a blood transfusion of whole blood or blood products?______________
Who is your primary care physician?______________
When was you last physical exam?__________By whom?______________
Have you ever been under the care of a physchiatrist or psychologist?__________No________Yes
Do you drink more than 6 cups of coffee, tea, cola or drinks with caffeine daily?__________No__________Yes
Do you take addicting drugs?______No______Yes Have you ever used street drugs?________No______Yes
Have you ever smoked in the past?______No_______Yes If Yes, for how many years?______#packs a day______
Age/date you quit smoking?______________
Do you take more than 2 alcoholic drinks per day?__________No__________Yes
Have you ever had tuberculosis or been exposed to it?________No__________Yes
Have you ever had hepatitis?________No________Yes
Do you have or have you ever had venereal disease or AIDS?________No________Yes
Have you ever been exposed to the HIV virus?__________No__________Yes

List all MEDICATIONS and DOSES (include aspirin, insulin, birth control, vitamins, natural supplements as well as Prescriptions:

____
____
____
____
____
____
____
____
____
____
____

ALLERGIES: Have you ever had reactions to the following:

Adhesive	No________	Yes_________
Antibiotics(Penicillin,Sulfa,Mycins)	No________	Yes_________
Betadine	No________	Yes_________
Etadyne	No________	Yes_________
Codeine	No________	Yes_________
Compazine	No________	Yes_________
Darvon	No________	Yes_________
Demerol	No________	Yes_________
Dilaudid	No________	Yes_________
Empirin	No________	Yes_________
X-ray dye/contrast	No________	Yes_________
Local Anesthetics	No________	Yes_________
Metals	No________	Yes_________
Morphine	No________	Yes_________
Aspirin	No________	Yes_________
Other medications (list)	No________	Yes_________

____

IS THERE ANY HISTORY OF THE FOLLOWING CONDITION IN YOUR FAMILY? IF SO, WHO?

Allergies	No_____	Yes_____	Who________________________________
Asthma	No_____	Yes_____	Who________________________________
Emphysema	No_____	Yes_____	Who________________________________
Bleeding tendencies	No_____	Yes_____	Who________________________________
Cancer	No_____	Yes_____	Who________________________________
Diabetes	No_____	Yes_____	Who________________________________
Epilepsy	No_____	Yes_____	Who________________________________
Heart Attack	No_____	Yes_____	Who________________________________
High Blood Pressure	No_____	Yes_____	Who________________________________
Depression/psychiatric problems	No_____	Yes_____	Who________________________________
Gallbladder disease	No_____	Yes_____	Who________________________________
Hernia	No_____	Yes_____	Who________________________________
Problems w/Anesthesia	No_____	Yes_____	Who________________________________
Stroke	No_____	Yes_____	Who________________________________
Tuberculosis	No_____	Yes_____	Who________________________________
Other	No_____	Yes_____	Who________________________________

Patient name(print)____

Patient signature____ Date_______________