Date:_____

Name:_____ Age:_____ Est Weight:_____ Height:_____

In brief, why are you seeing the doctor today?_____

List your allergies:_____

List your medications, including dosages:_____

_____

_____

Previous Biopsies?_____

Where _____

Have you had cancer? Yes__No_____

What Kind?_____

Have you had Chemotherapy?_____

Have you had radiation?_____

Previous Surgery/Hospitalization/Injuries/Severe Illness

Year	Where	What

QUESTIONS FOR WOMEN:

# of Children delivered _____ Ages_____

C-Section? _____ Complications_____

Last GYN Exam _____ Last PAP_____

Being treated for menstrual problems?_____

Could you be pregnant?_____

Do you have now: False teeth, caps on your teeth, artificial joints, tissue implants?_____

Do you require the assistance of: a walker, crutches, artificial limb, wheelchair, other?_____

Do you currently smoke, dip or chew, if so # per day?_____ Have you used tobacco in the past 24 months?_____
If you drink alcohol, # per week? _____

Family History: heart disease, hernia, anesthetic reactions, cancer, diabetes, kidney cysts or kidney failure, known inherited diseases, breast cancer, colon polyps, pulmonary embolism, phlebitis or blood clots, other? (circle) Other:_____

Father: alive, deceased, in good health, not in good health (circle one)
Mother: alive, deceased, in good health, not in good health (circle one)
Sister: alive, deceased, in good health, not in good health (circle one)
Brother: alive, deceased, in good health, not in good health (circle one)
Son: alive, deceased, in good health, not in good health (circle one)
Daughter: alive, deceased, in good health, not in good health (circle one)

Social/Occupational History:
Occupation_____
If retired, what did you do?_____
Frequently lift over: 10,25,50,100 lbs (circle)
Frequently: bend, squat, crawl, climb stairs, work in dirty or unclean conditions, sweat (circle)
Do you live alone?_____ with spouse or partner?_____ with children?_____ with other? (explain)_____
If you live alone, do you require someone to help you with your daily driving?_____meals?_____Bathing?_____
Do you live in a nursing home or assisted care facility?_____

Have you ever had an injection, IV, or gas for anesthesia? Yes_____ No_____
If yes, did you have any problems?_____

Who do you authorize the release of medical information to?_____
May we leave a message on your answering machine/voice-mail? Yes_____No_____

Referring Physician:_____ **Primary Physician:**_____

GEN/CONSTITUTIONAL:	**NO**	**YES**	**EXPLAIN**
LOSS OF APPETITE			
DEPRESSION			
WEAKNESS			
WEIGHT GAIN			
FATIGUE			
STRESS			
UNABLE TO SLEEP			
EYES:	**NO**	**YES**	**EXPLAIN**
RECENT CHANGE IN VISION OR SURGERY			
BLURRED VISION			
EYE PAIN			
DIMMING OF VISION			
ITCHING OR RED EYES			
LID SWELLING			
LIGHT SENSITIVITY			
SEEING FLASHING LIGHTS OR SPOTS			
EARS NOSE THROAT:	**NO**	**YES**	**EXPLAIN**
SINUS CONGESTION OR BLOCKAGE OF BREATHING			
HEADACHES			
NOSE BLEED			
HOARSENESS OR VOICE CHANGE			
HEARING LOSS OR RINGING			
DENTURES			
DIFFICULTY SWALLOWING			
MOUTH SORES			
RESP:	**NO**	**YES**	**EXPLAIN**
CHRONIC OR NEW COUGH OR NIGHT COUGH OR CHOKING			
ASTHMA OR WHEEZING			
SHORTNESS OF BREATH			
PRIOR ANESTHESIA PROBLEMS			
TUBERCULOSIS			
EMPHYSEMA OR COPD OR FREQUENT PNEUMONIA OR BRONCHITIS			
COUGHING UP BLOOD			
NIGHT SWEATS			

CARDIOVASCULAR:	**NO**	**YES**	**EXPLAIN**
STROKE OR CVA OR TIA			
SEVERE CHEST PAIN OR HEART ATTACK			
IRREGULAR HEARTBEAT OR PALPITATIONS OR VALVE PROLAPSE			
VARICOSE VEINS			
SWELLING IN LEGS OR ANKLES OR FEET			
LEP PAIN WITH WALKING OR FOOT/TOE PAIN AT NIGHT			
HIGH BLOOD PRESSURE OR TREATMENT FOR HYPERTENSION			
DIFFICULTY BREATHING AT NIGHT			
GASTROINTESTINAL:	**NO**	**YES**	**EXPLAIN**
ABDOMINAL PAIN OR ACHE OR BURN OR CRAMPING			
CONSTIPATION			
DIARRHEA			
YELLOW JAUNDICE OR HEPATITIS LIVER CIRRHOSIS			
VOMITING BLOOD OR COFFEE GROUNDS OR PASSING BLOOD OR BLACK BOWEL MOVEMENTS			
NAUSEA OR VOMITING			
HEARTBURN OR REGURGITATION OR BURNING IN CHEST			
HEMORRHOIDS			
HEMATOLOGIC/LYMPHATIC:	**NO**	**YES**	**EXPLAIN**
LUMPS IN THE NECK OR UNDER ARMS OR GROIN			
BRUISE OR BLEED EASILY			
ANEMIA			
BLEEDING PROBLEMS IN YOUR FAMILY			
HAVE YOU HAD A BLOOD TRANSFUSION?			
LUPUS OR RHEUMATOID ARTHRITIS			
HEAL POORLY OR SLOWLY			
SERIOUS BLEEDING AFTER SURGERY			
ENDOCRINE:	**NO**	**YES**	**EXPLAIN**
DO YOU HAVE DIABETES?			
LOW BLOOD SUGAR OR PASS OUT EASILY			
LOW THYROID			
HIGH THYROID			
HOT FLUSHES WITH WEAKNESS			
COLD INTOLERANCE			
REALLY SEVER EXPLAINED HEADACHE			
UNEXPLAINED PERIOD OF SEVERE WEAKNESS			

MUSCULOSKELETAL:	**NO**	**YES**	**EXPLAIN**
ARTHRITIS OR JOINT PAIN			
FIBROMYALGIA OR MUSCLE TENDERNESS OR ACHE			
BACK PAIN OR PAIN DOWN LOW BACK INTO BUTTOCKS OR LEGS			
CRAMPS IN BUTTOCK OR THIGH OR ARM OR CALF			
MAJOR INJURIES OR SURGERY			
NECK INJURIES OR SURGERY			
NEED CRUTCH OR WALKER OR WHEEL CHAIR			
FRACTURES OR BROKEN BONES			
SKIN:	**NO**	**YES**	**EXPLAIN**
CANCER			
EASY BRUISING			
COLOR CHANGE			
ITCHING			
NEW DARK MOLES			
SCARS TEND TO BE UGLY			
TATTOOS			
RASHES OR IRRITATION OR REDNESS OR CRACKING SKIN OR NAIL			
NEUROLOGIC:	**NO**	**YES**	**EXPLAIN**
HEADACHE OR MIGRAINES			
PRIOR CONCUSSION			
VERY PAINFUL OR SENSITIVE AREAS ON BODY TO TOUCH OR PRESSURE			
CONVULSIONS OR SEIZURES OR EPILEPSY			
EASY FAINTING OR BLACKOUTS			
PERIODS OF MEMORY LOSS			
BALANCE PROBLEMS OR FREQUENT FALLS			
VERY WEAK OR PARALYZED PARTS OF YOUR BODY			
PSYCHIATRIC	**NO**	**YES**	**EXPLAIN**
LOTS OF INAPPROPRIATE ANXIETY OR FEAR			
UNREASONABLE ANGER AND LOSS OF CONTROL			
DEPRESSION OR LOSS OF INTEREST			
SLEEP PROBLEMS			
UNEXPLAINED FATIGUE			
VOICES IN HEAD OR HALLUCINATIONS OR SUICIDAL THOUGHTS			
CONCERNED THAT YOU ARE LOSING CONTROL			
ALCOHOL OR OTHER DRUG/MEDICATION ABUSE			

BREASTS:	**NO**	**YES**	**EXPLAIN**
BREAST PAIN			
SWELLING			
LUMPS OR NODULES			
NIPPLE DISCHARGE			
SURGERY OR BIOPSY			
FAMILY HISTORY OF BREAST CANCER OR OVARIAN CANCER			
ABNORMAL MAMMOGRAM OR ULTRASOUND			
FIBROCYSTIC DISEASE			
GENITOURINARY MALE:	**NO**	**YES**	**EXPLAIN**
PAINFUL OR DIFFICULT URINATION			
PAINFUL INTERCOURSE OR IMPOTENCE			
UP TO PASS WATER MORE THAN ONCE AT NIGHT			
LOSING URINE OR PASSING WATER WITH COUGH OR SNEEZING OR INVOLUNTARILY			
ABNORMAL DRAINAGE, HERPES OR SYPHILIS OR GONORRHEA			
KIDNEY STONES			
A BLOODY OR BROWN OR SMOKY URINE			
KIDNEY OR BLADDER OR PROSTATE INFECTIONS			
GENITOURINARY FEMALE:	**NO**	**YES**	**EXPLAIN**
DELIVERED CHILDREN			
BLOOD IN URINE OR VAGINA			
PAINFUL MENSTRUATION			
LOSS OF URINE WITH COUGH OR SNEEZE OR OTHERWISE NOT CONTROLLED			
BLADDER OR KIDNEY INFECTION			
GONORRHEA OR SYPHYLLIS OR CHAMYDIA OR HERPES			
PELVIC INFECTIONS			
URINARY STONES			

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____