**PATIENT'S NAME:** _____ **DOB:** _____ **AGE:** _____

**DATE:** _____ **REASON FOR VISIT:** _____

## Patient's Past Medical History

☐ No prior serious illness

***Endocrine***

- Y ☐ N ☐ Diabetes
- Y ☐ N ☐ Thyroid Disease
- Y ☐ N ☐ High Cholesterol

***Eyes***

- Y ☐ N ☐ Glaucoma
- Y ☐ N ☐ Legally Blind

***Cardiovascular***

- Y ☐ N ☐ High Blood Pressure
- Y ☐ N ☐ Congestive Heart Failure
- Y ☐ N ☐ Prior Heart Attack
- Y ☐ N ☐ Coronary Heart Disease
- Y ☐ N ☐ Previous Hospitalization for Cardiac problem
- Y ☐ N ☐ Cardiac Catheterization
- Y ☐ N ☐ Non Healing Wound

***Respiratory***

- Y ☐ N ☐ Asthma
- Y ☐ N ☐ Emphysema
- Y ☐ N ☐ Bronchitis
- Y ☐ N ☐ Pneumonia
- Y ☐ N ☐ Tuberculosis
- Y ☐ N ☐ Shortness of Breath
- Y ☐ N ☐ Sleep Apnea

***Gastrointestinal***

- Y ☐ N ☐ Diverticulitis of Colon
- Y ☐ N ☐ Colonic Diverticulosis
- Y ☐ N ☐ GERD
- Y ☐ N ☐ Colon Cancer
- Y ☐ N ☐ Hepatitis
- Y ☐ N ☐ Cirrhosis
- Y ☐ N ☐ Ulcerative Colitis
- Y ☐ N ☐ Crohn's Disease
- Y ☐ N ☐ Hiatal Hernia
- Y ☐ N ☐ Irritable Bowel Syndrome

***Genitourinary***

- Y ☐ N ☐ Dialysis
- Y ☐ N ☐ Kidney Stones
- Y ☐ N ☐ Prostate Disorders
- Y ☐ N ☐ Renal Failure
- Y ☐ N ☐ End Stage Renal Disease
- Y ☐ N ☐ Renal Dialysis

***Musculoskeletal***

- Y ☐ N ☐ Arthritis
- Y ☐ N ☐ Gout
- Y ☐ N ☐ Lupus
- Y ☐ N ☐ Fibromyalgia

***Breast***

- Y ☐ N ☐ Breast Cancer
- Y ☐ N ☐ Skin Cancer
- Y ☐ N ☐ Scleroderma

***Neurologic***

- Y ☐ N ☐ Stroke Syndrome
- Y ☐ N ☐ Seizure Disorder
- Y ☐ N ☐ Brain Aneurysm
- Y ☐ N ☐ Neuropathy (weakness hands/feet)

***Hematologic/Lymph***

- Y ☐ N ☐ Blood Clots
- Y ☐ N ☐ Anemia
- Y ☐ N ☐ HIV
- Y ☐ N ☐ Hodgkin's Disease
- Y ☐ N ☐ Leukemia
- Y ☐ N ☐ Lymphoma

## Social History

- Y ☐ N ☐ Alcohol Use
- Y ☐ N ☐ Caffeine Use
- Y ☐ N ☐ Recreational Drug Use

M=Mother, F=Father, B=Brother, S=Sister, GM/GF=Grandmother/Father

| Family History | | | | M, F, B, S | GM/GF |
|---|---|---|---|---|---|
| Y ☐ | N ☐ | Heart Disease | | | |
| Y ☐ | N ☐ | High Blood Pressure | | | |
| Y ☐ | N ☐ | Diabetes | | | |
| Y ☐ | N ☐ | Stroke Syndrome | | | |
| Y ☐ | N ☐ | Colon Cancer | | | |
| Y ☐ | N ☐ | Breast Cancer | | | |

## Past Surgical History

***Arterial Surgery***

- Y ☐ N ☐ Aneurysm Repair (AAA)
- Y ☐ N ☐ Previous Coronary Artery Bypass
- Y ☐ N ☐ Atherosclerosis of Bypass Graft of the extremities (Leg/Bypass)
- Y ☐ N ☐ Peripheral Stent (Leg/Trunk Stent)

**PATIENT'S NAME:** _____ **DOB:** _____

## Past Surgical History (cont)

***Musculoskeletal Surgery***

- Y ☐ N ☐ Back Surgery
- Y ☐ N ☐ Total Hip Replacement
- Y ☐ N ☐ Knee Replacement
- Y ☐ N ☐ Rotator Cuff Repair
- Y ☐ N ☐ Fracture

***Gastrointestinal Surgery***

- Y ☐ N ☐ Appendectomy
- Y ☐ N ☐ Gallbladder Surgery
- Y ☐ N ☐ Partial Colectomy (colon resection)
- Y ☐ N ☐ Colostomy
- Y ☐ N ☐ Ileostomy
- Y ☐ N ☐ Hemorrhoidectomy
- Y ☐ N ☐ Small Bowel Resection
- Y ☐ N ☐ Splenectomy
- Y ☐ N ☐ Pancreatectomy
- Y ☐ N ☐ Stomach Ulcer Surgery

***Head & Neck Surgery***

- Y ☐ N ☐ Thyroid Surgery
- Y ☐ N ☐ Parathyroid Surgery
- Y ☐ N ☐ Carotid Surgery or Stent
- Y ☐ N ☐ Tonsillectomy/Adenoidectomy

***Cardiac/Thoracic Surgery***

- Y ☐ N ☐ Heart Valve Replacement
- Y ☐ N ☐ Heart Bypass (CABG)
- Y ☐ N ☐ Cardiac Pacemaker Placement
- Y ☐ N ☐ Cardioverter-Defibrillator
- Y ☐ N ☐ Heart Stent Placement
- Y ☐ N ☐ Lung Surgery

***Genitourinary Surgery***

- Y ☐ N ☐ Nephrectomy
- Y ☐ N ☐ Lithotripsy
- Y ☐ N ☐ Prostate Surgery

***Hernia Surgery***

- Y ☐ N ☐ Inguinal Hernia Repair (Groin)
- Y ☐ N ☐ Umbilical Hernia Repair (Navel)
- Y ☐ N ☐ Femoral Hernia Repair
- Y ☐ N ☐ Incisional Hernia Repair
- Y ☐ N ☐ Ventral Hernia Repair (Abdominal)

***Female Surgery***

- Y ☐ N ☐ Breast Surgery
- Y ☐ N ☐ Hysterectomy
- Y ☐ N ☐ Tubal Ligation
- Y ☐ N ☐ Cesarean Surgery

***Other Surgeries***

- Y ☐ N ☐ Craniotomy
- Y ☐ N ☐ Temporal Artery Biopsy
- Y ☐ N ☐ Cataract Surgery

## Review of Systems (Current Symptoms)

***Constitutional***

- Y ☐ N ☐ Recent Weight Gain of _____ lbs
- Y ☐ N ☐ Recent Weight Loss of _____ lbs
- Y ☐ N ☐ Fever (as a symptom)

***Eyes***

- Y ☐ N ☐ Pain in or around Eyes
- Y ☐ N ☐ Vision Problems

***ENMT***

- Y ☐ N ☐ Loss of Hearing
- Y ☐ N ☐ Bleeding Gums

***Cardiovascular***

- Y ☐ N ☐ Chest Pain or Discomfort
- Y ☐ N ☐ Heart Rate is Fast
- Y ☐ N ☐ Chest Pain when climbing stairs

***Respiratory***

- Y ☐ N ☐ Cough
- Y ☐ N ☐ Shortness of Breath

***Gastrointestinal***

- Y ☐ N ☐ Black or Bloody Stools
- Y ☐ N ☐ Yellow Skin or Eyes (Jaundice)
- Y ☐ N ☐ Nausea
- Y ☐ N ☐ Vomitting
- Y ☐ N ☐ Constipation
- Y ☐ N ☐ Diarrhea
- Y ☐ N ☐ Abdominal Pain
- Y ☐ N ☐ GERD

***Genitourinary***

- Y ☐ N ☐ Blood in Urine
- Y ☐ N ☐ Urinary Frequency
- Y ☐ N ☐ Pain During Urination

**Date of last Mammogram**_____ **Never (circle)**

**Date of last Colonoscopy**_____ **Never (circle)**

***Musculoskeletal***

- Y ☐ N ☐ Leg Pain with Exercise
- Y ☐ N ☐ Localized Soft Tissue Swelling of the Leg

***Psychiatric***

- Y ☐ N ☐ Depression
- Y ☐ N ☐ Anxiety
- Y ☐ N ☐ Memory Lapses or loss

***Skin/Breast***

- Y ☐ N ☐ Breast Lump ____ Right ____ Left
- Y ☐ N ☐ Breast Pain ____ Right ____ Left
- Y ☐ N ☐ Skin Lesions
- Y ☐ N ☐ Skin Rash

***Neurologic***

- Y ☐ N ☐ Dizziness
- Y ☐ N ☐ Confusion

**PATIENT'S NAME:** _____ **DOB:** _____

***Hematologic/Lymph***

Y☐ N☐ Easy Bleeding
Y☐ N☐ Easy Bruising Tendency
Y☐ N☐ Swollen Glands in the Neck
Y☐ N☐ Groin Lymph Nodes Swelling

***Other***

Y☐ N☐ Patient believes she is pregnant
Y☐ N☐ Periods of not breathing while asleep
___Never Smoked ___ Former Smoker ___ Current Smoker

Y☐ N☐ Flu Vaccine
Y☐ N☐ Pneumococcal Vaccine
Y☐ N☐ PTCA, if so what year _____

**CURRENT MEDICATIONS**

| NAME OF MEDICATION | DOSAGE (mg, tsp, etc) | HOW MANY TIMES PER DAY |
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**ALLERGIES**

| MEDICATION YOU ARE ALLERGIC TO: | REACTION YOU HAVE: |
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| | |

Y☐ N☐ ALLEGRIC TO LATEX
Y☐ N☐ HAVE YOU BEEN PRESCRIBED A NARCOTIC/PAIN MEDICATION BY ANOTHER MD IN THE LAST 30 DAYS?
Y☐ N☐ ARE YOU CURRNETLY ENROLLED IN A PAIN MANAGEMENT CLINIC?

**HEIGHT:** _____ **WEIGHT:** _____

******PLEASE GIVE THIS FORM TO THE RECEPTIONIST AS SOON AS YOU COMPLETE IT.**