

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

## SOCIAL HISTORY

Dietary Intolerance: \_\_\_\_\_ Exercise Habits: \_\_\_\_\_

Number of Children: \_\_\_\_\_ Hobbies: \_\_\_\_\_ Occupation: \_\_\_\_\_

Do you live: Alone \_\_\_\_\_ with Spouse \_\_\_\_\_ with Family \_\_\_\_\_ Other \_\_\_\_\_ State/Country of Birth \_\_\_\_\_

Please indicate TOBACCO USE: \_\_\_\_\_ None

\_\_\_\_\_ Cigarettes: \_\_\_\_\_ packs per day \_\_\_\_\_ years of use Quit: \_\_\_\_\_ (please list year)

\_\_\_\_\_ Other (cigar/snuff) \_\_\_\_\_ frequency/day \_\_\_\_\_ years of use Quit: \_\_\_\_\_ (please list year)

Please indicate ALCOHOL USE: \_\_\_\_\_ None \_\_\_\_\_ daily \_\_\_\_\_ weekly \_\_\_\_\_ occasionally \_\_\_\_\_ quit (what year) \_\_\_\_\_

## REVIEW OF SYSTEMS

*Please check any symptom or disease diagnosed during the last 12 months*

<b>GENERAL</b> _____ Loss of Appetite/Anorexia _____ Fatigue _____ Fever _____ Night Sweats _____ Weight gain in the last 12 months Amount _____ _____ Weight loss in the last 12 months Amount _____ _____ Are you under any stress?	<b>GENITOURINARY</b> _____ Blood in urine _____ Painful urination _____ Frequent urination _____ Urgency with urination  <b>RESPIRATORY</b> _____ Cough _____ Shortness of Breath _____ Wheezing  <b>CARDIOVASCULAR</b> _____ Chest Pain _____ Claudications _____ Edema/Swelling _____ Night Cramps _____ Difficulty breathing while laying down _____ Palpitations _____ Sleep Apnea _____ Shortness of Breath _____ Congestive Heart Failure _____ Myocardial Infarction _____ Valve Replacement  <b>ENDOCRINE</b> _____ Extreme thirst  <b>SEXUAL HISTORY</b> _____ Active _____ Inactive _____ Heterosexual _____ Homosexual	<b>NEUROLOGICAL</b> _____ Difficulty Speaking _____ Focal Neurological Symptoms _____ Syncope _____ Incontinence Urine _____ Incontinence Stool _____ Seizure  <b>PSYCHIATRIC</b> _____ Feel scared or anxious _____ Depression _____ Feel like crying for no reason _____ Insomnia/Trouble Sleeping  <b>GASTROINTESTINAL</b> _____ Frequent constipation _____ Pain with bowel movement _____ Mucus in or on your stool _____ Frequent diarrhea _____ Black or sticky stools _____ Vomit frequently _____ Vomit blood or "coffee grounds" _____ Bloating, belching or excessive gas _____ Difficult or painful swallowing _____ Frequent heartburn or indigestion _____ Frequent stomach pain _____ Changes on bowel movements  _____ Last Gynecological Exam _____ Last Mammogram
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**CHECK ALL DISEASES THAT HAVE OCCURRED IN YOUR FAMILY and INDICATE FAMILY MEMBER AFFECTED**

Anemia	Breast Cancer	Cirrhosis of Liver	Colon Polyps	Colorectal Cancer
Crohn's Disease	Diabetes, NIDDM	Diabetes, Insulin Dependant	Gastric Cancer	Gallstones
Heart Disease	Hemochromatosis	Irritable Bowel Syndrome	Liver Disease	Gynecological Cancer
Pancreatic Cancer	Acute Pancreatitis	Chronic Pancreatitis	Peptic Ulcer Disease	Ulcerative Colitis

**PAST MEDICAL HISTORY: Check all that Apply to Your Past and Present Medical History**

<p><b>LIVER</b></p> <p><input type="checkbox"/> Hemochromatosis</p> <p><input type="checkbox"/> Cirrhosis</p> <p><input type="checkbox"/> Hep A</p> <p><input type="checkbox"/> Hep B</p> <p><input type="checkbox"/> Hep C</p> <p><input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> Fatty Liver</p> <p><b>HEART</b></p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> Angina</p> <p><input type="checkbox"/> Congestive Heart Failure</p> <p><input type="checkbox"/> Premature Heart Failure</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Mitral Valve Prolapse</p> <p><input type="checkbox"/> Elevated Triglycerides</p> <p><input type="checkbox"/> Elevated Cholesterol</p> <p><input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> Heart Valve Disease</p> <p><input type="checkbox"/> Endocarditis</p> <p><b>BLOOD</b></p> <p><input type="checkbox"/> VonWillebrands'</p> <p><input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> Bleeding or clotting abnormalities</p> <p><input type="checkbox"/> History of Blood or Blood product Transfusion</p> <p><b>INTEGUMENTARY</b></p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Skin Cancer</p> <p><input type="checkbox"/> Melanoma</p> <p><input type="checkbox"/> Psoriasis</p>	<p><b>CANCER</b></p> <p><input type="checkbox"/> Colon Cancer</p> <p><input type="checkbox"/> Esophageal Cancer</p> <p><input type="checkbox"/> Stomach Cancer</p> <p><input type="checkbox"/> Breast Cancer</p> <p><input type="checkbox"/> Pancreatic Cancer</p> <p><input type="checkbox"/> Endometrial Cancer</p> <p><input type="checkbox"/> Barrett's Esophagus</p> <p><input type="checkbox"/> Liver Cancer</p> <p><input type="checkbox"/> Leukemia</p> <p><input type="checkbox"/> Lymphoma</p> <p><b>RENAL</b></p> <p><input type="checkbox"/> Kidney Stones</p> <p><input type="checkbox"/> Kidney Failure</p> <p><input type="checkbox"/> Dialysis</p> <p><b>MUSCULOSKELETAL</b></p> <p><input type="checkbox"/> Fibromyalgia</p> <p><input type="checkbox"/> Osteoarthritis</p> <p><input type="checkbox"/> Rheumatoid Arthritis</p> <p><input type="checkbox"/> Reynaud's</p> <p><input type="checkbox"/> Lupus</p> <p><input type="checkbox"/> Sjogrens</p> <p><input type="checkbox"/> Scleroderma</p> <p><input type="checkbox"/> Gout</p> <p><b>PSYCHOLOGICAL</b></p> <p><input type="checkbox"/> Bipolar</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> OC Disorder</p> <p><input type="checkbox"/> Schizophrenia</p>	<p><b>NEUROLOGICAL</b></p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Migraines</p> <p><input type="checkbox"/> Other Headache</p> <p><b>RESPIRATORY</b></p> <p><input type="checkbox"/> COPD (emphysema)</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Tuberculosis (TB)</p> <p><input type="checkbox"/> Sleep Apnea</p> <p><input type="checkbox"/> Collapsed Lung</p> <p><b>GASTROENTESTINAL</b></p> <p><input type="checkbox"/> IBS (Irritable Bowel Syndrome)</p> <p><input type="checkbox"/> Diverticulitis</p> <p><input type="checkbox"/> Diverticulosis</p> <p><input type="checkbox"/> Peptic Ulcer Disease</p> <p><input type="checkbox"/> Angiodysplasia of GI tract</p> <p><input type="checkbox"/> Gallstones</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Reflux Esophagitis</p> <p><input type="checkbox"/> IBD-Crohn's</p> <p><input type="checkbox"/> IBD-Ulcertive Colitis</p> <p><input type="checkbox"/> Pancreatitis</p> <p><b>ENDOCRINOLOGY</b></p> <p><input type="checkbox"/> Diabetes, type I (insulin needed)</p> <p><input type="checkbox"/> Diabetes, Type II (pills needed)</p> <p><input type="checkbox"/> Thyroid Disease</p> <p><input type="checkbox"/> Hypothyroid</p> <p><input type="checkbox"/> Hyperthyroid</p>
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**SURGICAL PROCEDURES/HOSPITALIZATIONS:**

<p><b>GASTROENTESTINAL</b></p> <p><input type="checkbox"/> Appendectomy</p> <p><input type="checkbox"/> Hiatal Hernia Repair</p> <p><input type="checkbox"/> Gallbladder Removal</p> <p><input type="checkbox"/> Exploratory Surgery for Intestinal Adhesions</p> <p><input type="checkbox"/> Gastric Bypass</p> <p><input type="checkbox"/> Colon Resection, Partial</p> <p><input type="checkbox"/> Gastric Resection, Complete</p> <p><input type="checkbox"/> Splenectomy (removal of spleen)</p> <p><input type="checkbox"/> Ventral Hernia</p> <p><input type="checkbox"/> Incisional Hernia</p> <p><input type="checkbox"/> Colonoscopy</p> <p><input type="checkbox"/> Upper Endoscopy</p> <p><input type="checkbox"/> ERCP</p> <p><input type="checkbox"/> Whipple</p>	<p><b>GYNECOLOGICAL</b></p> <p><input type="checkbox"/> Vaginal Hysterectomy</p> <p><input type="checkbox"/> Abdominal Hysterectomy</p> <p><input type="checkbox"/> Ovary Removal</p> <p><input type="checkbox"/> C-Section</p> <p><input type="checkbox"/> Breast Biopsy</p> <p><input type="checkbox"/> Mastectomy</p> <p><b>GU</b></p> <p><input type="checkbox"/> TURP</p> <p><input type="checkbox"/> Bladder Surgery</p> <p><input type="checkbox"/> Inguinal Hernia</p> <p><input type="checkbox"/> Cystectomy with Ileal conduit</p> <p><input type="checkbox"/> Kidney Removal</p> <p><input type="checkbox"/> Prostate Removal</p> <p><input type="checkbox"/> Radiation for Prostate Cancer</p>	<p><b>CARDIAC</b></p> <p><input type="checkbox"/> Heart Stent placed</p> <p><input type="checkbox"/> CABG</p> <p><input type="checkbox"/> Abdominal Aneurysm repair</p> <p><input type="checkbox"/> FemPop Bypass (Leg Arteries)</p> <p><input type="checkbox"/> Heart Valve replacement</p> <p><input type="checkbox"/> Pacemaker (Please present cards)</p> <p><input type="checkbox"/> Difibulator (Please present cards)</p> <p><b>OTHER</b></p> <p><input type="checkbox"/> Thyroidectomy</p> <p><input type="checkbox"/> Tonsillectomy</p> <p><input type="checkbox"/> Glaucoma Surgery</p> <p><input type="checkbox"/> Cataract Surgery</p> <p><input type="checkbox"/> Laser Surgery</p> <p><b>ORTHOPEDIC</b></p> <p><input type="checkbox"/> Artificial Joints</p> <p>If so when placed? _____</p>
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**CURRENT MEDICATION FLOW SHEET**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Have You Ever Had a Reaction From Anesthesia? YES or NO If yes Explain:** \_\_\_\_\_

**Have You Ever Had a Reaction From Latex? YES or NO If yes Explain:** \_\_\_\_\_

**LIST MEDICATIONS AND DOSAGE**

PLEASE INCLUDE HERBAL AND OTC	Leave Blank for Nurse to Complete These Columns Below						
	↓			↓			↓
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

Do you have a pacemaker?            YES \_\_\_\_\_    NO \_\_\_\_\_

Do you have a defibrillator?        YES \_\_\_\_\_    NO \_\_\_\_\_  
(If yes to the above, may we make a copy of your card?)

Do you have any artificial Joints?    YES \_\_\_\_\_    NO \_\_\_\_\_  
If so, what and when placed? \_\_\_\_\_