

Patient History

Date:

Name:	Age:	M or F
Date of Birth:	Marital Status: M S D W	
Primary Physician:	Daytime phone #:	

Reason for visit (Describe all pertinent symptoms):

Past Medical History (List all medical problems):

Previous Surgeries:

Anesthesia complications? (You or a family member)

Current Medications (List dose, frequency and bring medications with you to appointment):

Allergies to medications:

Occupation:	Living Will?:
Tobacco use (Type, amount, for how long, when quit):	
Alcohol use (Type, amount, for how long, when quit):	
Illicit drug use (Type, method, when):	

Family History (List illnesses, current age or age at death and cause of death for each):

Mother:

Father:

Sister:

Brother:

Other:

Any illnesses which are prevalent in your family:

SYSTEM REVIEW

General	Yes	No	Comment
Weight Gain/Loss	()	()	_____
Fevers	()	()	_____
Night Sweats	()	()	_____
Appetite	()	()	_____
Eyes			
Visual Change	()	()	_____
Eye Surgery	()	()	_____
Glaucoma	()	()	_____
ENT & Mouth			
Hearing problems	()	()	_____
Frequent nose bleeds	()	()	_____
sinus Problems	()	()	_____
Sores in mouth/throat	()	()	_____
Difficulty swallowing	()	()	_____
Lump sensation in throat	()	()	_____
Hoarseness	()	()	_____
Cardiovascular			
Heart attack	()	()	_____
High blood pressure	()	()	_____
Chest pain (angina)	()	()	_____
Heart surgery	()	()	_____
Congestive heart failure	()	()	_____
Shortness of breath	()	()	_____
Circulatory problems	()	()	_____
Leg cramps	()	()	_____
Foot pain/sores	()	()	_____
Surgery on arteries	()	()	_____
Phlebitis/blood clots	()	()	_____
Leg ulcers	()	()	_____
Respiratory			
Emphysema	()	()	_____
Chronic Cough	()	()	_____
Cough blood	()	()	_____
Lung surgery	()	()	_____
Pneumonia	()	()	_____
Asthma/Bronchitis	()	()	_____
Blood clots in lung	()	()	_____
Sleep apnea	()	()	_____
Gastrointestinal			
Abdominal pain	()	()	_____
Abdominal surgery	()	()	_____
Bloody vomiting	()	()	_____
History of ulcers	()	()	_____
Bowel changes	()	()	_____
Bloody/black stool	()	()	_____
Heartburn	()	()	_____
Jaundice	()	()	_____

Women Only			
Last menstrual period	Yes	No	Comment
Birth control	()	()	_____
Menopause	()	()	_____
Pap smear/pelvic exam	()	()	_____
Pregnant now	()	()	_____
No. of Pregnancies _____ Births _____ Miscarriages _____			

Musculoskeletal	()	()	_____
Hernia	()	()	_____
Arthritis	()	()	_____
Rheumatoid disease	()	()	_____
Muscle wasting/weakness	()	()	_____
Osteoporosis	()	()	_____
Orthopedic surgery	()	()	_____
Skin/Breast			
Skin cancer	()	()	_____
Non-healing sores	()	()	_____
Breast lump/biopsy	()	()	_____
Breast pain	()	()	_____
Nipple discharge	()	()	_____
Dimpling of breast skin	()	()	_____
Breast cancer	()	()	_____
Mammogram (when)	()	()	_____
Neurological			
Stroke	()	()	_____
Seizure/Epilepsy	()	()	_____
Severe head injury	()	()	_____
Numbness/tingling	()	()	_____
Psychiatric			
Depression	()	()	_____
Schizophrenia	()	()	_____
Other Psychiatric	()	()	_____
Endocrine			
Diabetes/metabolic disease	()	()	_____
Thyroid/Glandular disease	()	()	_____
High cholesterol	()	()	_____
Hematologic			
Bleeding disorder	()	()	_____
Take aspirin	()	()	_____
Blood transfusion	()	()	_____
Blood diseases	()	()	_____
Lumps	()	()	_____
Neck	()	()	_____
Armpits	()	()	_____
Groin	()	()	_____
Allergic/Immunologic			
Exposure to communicable diseases			
AIDS/HIV	()	()	_____
Hepatitis	()	()	_____
Tetanus vaccine (when)	()	()	_____
Prednisone/steroid use	()	()	_____
Genitourinary			
Kidney disease/Stones	()	()	_____
Painful/Bloody urination	()	()	_____
Difficult urination	()	()	_____

Dr. Initials/Date: _____



Today's date: _____ Who may we thank for referring you: _____

Patient's name: _____
Last First Middle

Date of Birth: _____ Sex: Male Female Social Security #: _____

Residence Address: _____
Street City State Zip

Mailing Address (if different): _____
Street City State Zip

Home Phone: _____ Cell: _____ Email: _____

Marital Status: Single Married Widowed Other
Student Status: FT PT Not a Student

Patient Employer: _____ Full Time Part Time
Occupation : _____ Work Phone: _____ Is heavy lifting required? Yes No
Contact: _____
Name Title Phone Ext.

Spouse Name: _____
Date of Birth: _____ Social Security #: _____
Spouse Employer: _____ Work Phone: _____

Patient Primary Insurance Carrier: _____
Subscriber Name: _____ Policy #: _____
Group #: _____ Group Name: _____
Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Patient Secondary Insurance Carrier: _____
Subscriber Name: _____ Policy #: _____
Group #: _____ Group Name: _____
Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Please give us the name and phone number of a friend or family member **outside of the home** who can take a message for you if you are unavailable:

Name: _____ Phone #: _____
Relationship: _____

In case of an EMERGENCY please contact:

Name: _____ Phone #: _____
Relationship: _____

Patient Signature: _____ Date: _____