



Name	DOB	Date
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**PAST SURGICAL AND HOSPITAL HISTORY: None Yes, if yes**  
 Please describe your past experience with, **operations**, serious injuries, all and any hospitalizations and related treatments. Please include dates (month/year) of any surgeries.


**FAMILY HISTORY**

Are there medical events in your family's history, including diseases that may be hereditary or place you at risk?  
 Please circle **Y** or **N** for each condition ( no blanks please ☺ )

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
Y	N	High blood pressure	Y	N	Heart disease	Y	N	Thyroid disease
Y	N	Stroke	Y	N	Diabetes	Y	N	Asthma
Y	N	Kidney disease	Y	N	Liver disease	Y	N	Breast disease
Y	N	Cancer (indicate type)						
Y	N	Other						

**SOCIAL HISTORY**

Marital Status	Drug/Alcohol Use: Yes No	Tobacco Use: Yes No
Single Married Widowed Separated Divorced	Drinks/week	Cigarettes/day
Highest Level of Education	Employment (please include job title)	
Race		
Caucasian African American Hispanic Asian American Other		

**REVIEW OF SYSTEMS**

Do you have or have you had any serious or chronic medical conditions?  
 Please Circle **Y** or **N** or any condition(s) you have had or that you have currently. ( no blanks please ☺ )

	Yes	No		Yes	No		Yes	No
<b>Constitutional:</b> Weight change	Y	N	Fatigue	Y	N			
<b>Eyes:</b> Vision changes	Y	N	Cataracts	Y	N	Glaucoma	Y	N
<b>Ears/Nose/Mouth/Throat:</b> Ulcers	Y	N	URI (upper respiratory infection)	Y	N			
<b>Cardiovascular:</b> Chest pain	Y	N	Orthopnea (difficulty breathing when lying down)	Y	N	DOE (difficulty breathing on exertion)	Y	N
<b>Respiratory:</b> SOB (short of breath)	Y	N	Wheezing	Y	N			
<b>Gastrointestinal:</b> Nausea/Vomiting	Y	N	Diarrhea	Y	N	Bloody Stool	Y	N
<b>Musculoskeletal:</b> Weakness	Y	N						
<b>Integumentary/Skin:</b> Rash	Y	N						
<b>Neurological:</b> Seizure	Y	N	Syncope (fainting)	Y	N	Neuropathy	Y	N
<b>Psychiatric:</b> Depression	Y	N	Anxiety	Y	N			
<b>Endocrine:</b> Hot flashes	Y	N	Diabetes	Y	N	Thyroid	Y	N
<b>Hematologic/Lymphatic:</b> Easy bruising	Y	N	Bleeding	Y	N	Adenopathy (Swollen Glands)	Y	N
<b>Allergic/Immunologic:</b> Seasonal	Y	N	Animal Dander / Foods	Y	N			
Other:								

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date

Reviewed with Patient \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Drs Initials & Date