Patient Name_____ **Today's Date**_____
Age_____ **Date of Birth**_____ **Patient's Phone Number**_____

Referring Physician_____ **Primary Care Physician**_____
Other treating physicians_____

History of Present Illness (Describe in detail what is bothering you, when started, treatments, tests performed)
_____
_____
_____
_____
_____

Past Medical History (List all hospitalizations and illnesses for which you have been treated, e.g. diabetes, hypertension, heart disease, lung disorders, etc.)
_____
_____
_____
_____
_____

Past Surgical History (List all operations and major injuries)
_____
_____
_____
_____
_____

Allergies and Adverse Reactions (Include allergies to antibiotics, Latex, X-ray, dye, skin preps, pain medications if applicable)
_____
_____

Blood Transfusions: I will accept blood products in an emergency 1. YES___ 2. NO___
Have you ever had transfusion reactions? 3. YES___ 4. NO___

Current Medications (Include insulin, steroids, inhalers, oxygen, eyedrops, etc.)

Drug	Dose	Frequency	Drug	Dose	Frequency

SOCIAL HISTORY CIRCLE ALL THAT APPLY

Marital Status 1. Single 2. Married with ___children 3. Divorced since _____ 4. Widowed since _____
Living Will 1. Yes 2. No
Occupation _____
Tobacco 1. None 2. Currently smoke ___packs/day and have done so for ____ years
3. Previously smoked ____ packs/day for ___ years. Stopped in ____ 5. Smokeless tobacco
Alcohol 1. None 2. Minimal 3. Moderate 4. Heavy 5. Previously Heavy
Caffeine 1. None 2. 1-3 servings daily 3. 4-6 servings daily 4. More than 6 servings daily

Drug Use 1. Marijuana 2. Cocaine 3. Crack 4. Heroin 5. Other (list) _____

Family History (Please include history of diabetes, heart disease, hypertension, or cancer)

	ALIVE/DECEASED	AGE	HEALTH PROBLEMS/CAUSE OF DEATH
Father			
Mother			
Brothers/Sisters			

Is there a family history of breast or ovarian cancer? (who, at what age, breast or ovarian)
_____

PLEASE COMPLETE THE NEXT PAGE

Patient Name _____ **Today's Date** _____

PLEASE CIRCLE ANY SYMPTOMS/PROBLEMS YOU HAVE AN EXPLAIN BELOW

GENERAL Recent change in appetite, weight gain, or weight loss. Fevers, chills, or sweats.

HEAD Occasional mild headaches [4] Migraines [5] Recent trauma or concussion [6]

EYES Recent visual changes or double vision. Presbyopia (need bifocals) [4] Cataracts [5] Glaucoma [6]

EARS Ringing, infection, drainage, or pain. Mild hearing loss [4] Hearing impaired, use hearing aid [5]

NOSE/THROAT Frequent nose bleeds, bleeding gums, sores in mouth or lips, difficulty swallowing, or hoarseness. Chronic sinus congestion, allergies, or hay fever [4] Loose/broken teeth, dentures [5] Loud snoring [6]

LUNGS Wheezing, chronic cough, emphysema or COPD [5], coughing up blood. TB or positive skin test [4], Sleep apnea or use CPAP [6] Pulmonary embolus [7] Asthma [8]

HEART Chest pain or angina, heart skips, rapid heart rate, exertional or nocturnal shortness of breath. Cardiac testing within the last year (EKG, stress test, cardiac catheterization, or echo) [4] Heart attack [5] Atrial fibrillation [6] Pacemaker [7] Mitral valve prolapse [8] Hypertension [9]

BREAST Current breast mass, nipple discharge, personal history of breast cancer [4] Breast augmentation [5] Current abnormal mammogram or sonogram [2] Last mammogram_____(month and year) [6] Over due for mammogram [7]

DIGESTIVE Abdominal pain, nausea, vomiting, bloating, heartburn or GERD, diarrhea, constipation [4], Cirrhosis, jaundice [5] Gallstones [6] Black stools, blood in stool, hemorrhoid problems [7] History of cancer, Crohn's disease, ulcerative colitis, diverticulosis, or irritable bowel disease [3]

GENITO-URINARY MEN Difficulty urinating, difficulty holding urine, frequent urination at night [mild 4, severe 5] [1] Prostate cancer [6] Blood in urine, kidney stones [11] Herpes [13] Discharge from penis

WOMEN Difficulty urinating, difficulty hoding urine, frequent urination at night [mild 4, severe 5] [7] Menopause[8] at age___ Hysterectomy[9] at age___Were ovaries removed?[10] _____ Blood in urine, kidney stones[11] Genital Herpes[13] Last menstrual period_____

MUSCULOSKELETAL Pain in joints [4], pain in muscles, muscle weakness, fibromyalgia [5], arthritis under treatment [6] Chronic back problems [7] Swollen ankles, varicose veins [8]

NEUROLOGICAL Dizziness [4], loss of consciousness, transient loss of function, stroke [5], seizures [6]

SKIN Rash, psoriasis, non healing lesions, history of skin cancers or melanoma

EMOTIONAL Anxiety, depression, psychiatric therapy. Current treatment for depression or anxiety [4]

ENDOCRINE Thyroid disorder, masses, heat or cold intolerance, or taking thyroid medication [4] Diabetes under treatment [5], excessive thirst, hunger, or urination. Adrenal or pituitary disorder.

HEMATOLOGIC Anemia, bruise easily, excessive bleeding, swollen glands, leukemia, lymphoma, transfusions Blood clots, phlebitis, deep venous thrombosis [4], anticoagulated with coumadin [5], sickle cell [6]

INFECTIONS HIV Positive [4], history of hepatitis (type _____)[5], staph infections, MRSA or ORSA [6]

I have fully completed the above form and verify its accuracy.

Patient's Signature:_____ **Date:** _____

Reviewed by: _____