

Name _____ Today's Date _____

Date of Birth _____ Sex _____

PATIENT HISTORY
Shaded area completed by nurse

BP _____	Pulse _____	Resp _____	Height _____
Allergies _____		Weight _____	

Past History Of:

Cardiac

- _____ High Blood Pressure
- _____ Heart Disease
- _____ Angina (Chest Pain)
- _____ Irregular Heartbeats
- _____ Heart Attack
- _____ Rheumatic Fever
- _____ High Cholesterol

Neurologic

- _____ Stroke
- _____ Seizures
- _____ Other Neurologic Disorders
- Type: _____

GI

- _____ Ulcers
- _____ Diabetes
- _____ Jaundice
- _____ Hepatitis A B C
- _____ Reflux
- _____ Bowel Disorder
- _____ Bladder Disorder

Blood Disorder

- _____ Anemia
- _____ Sickle Cell
- _____ Bleeding Disorder
- _____ Hemophilia

Pulmonary

- _____ Asthma
- _____ Lung Disease
- _____ Pneumonia
- _____ Emphysema
- _____ Tuberculosis
- _____ Chronic Bronchitis
- _____ Sleep Apnea

Other

- _____ Thyroid Disease/Type _____
- _____ Cancer/Type _____
- _____ Sexually Transmitted Disease
- Type _____
- _____ HIV / AIDS

Orthopedic

- _____ Fracture: Location: _____
- _____ Joint Replacement: Location: _____
- _____ Rheumatoid Arthritis: Location: _____

Psychiatric

- _____ Depression
- _____ Bipolar Disorder
- _____ Anxiety / Panic Attacks

List any medical problems not listed above: _____

List all medications you take including aspirin and anti-inflammatory drugs:

Medication	Dosage	Reason for Taking

List all hospital admissions or surgeries and the year it occurred

Surgery or Hospitalization	Nature of injury/illness/Type of Surgery	Year

Review of Systems (circle yes or no)

Constitutional

Yes / No Weight Loss
 Yes / No Weight Gain
 Yes / No Fevers
 Yes / No Chills
 Yes / No Night Sweats
 Yes / No Lethargy (tired all the time)

Cardiac

Yes / No Chest Pain
 Yes / No Shortness of Breath
 Yes / No Leg Swelling

Lungs

Yes / No Chronic Cough
 Yes / No Wheezing
 Yes / No CPAP @ Night
 Yes / No Shortness of Breath

Psychiatric

Yes / No Depression
 Yes / No Anxiety
 Yes / No Sleep Disturbance

GI

Yes / No Incontinence of Bowel
 Yes / No Stomach Pain
 Yes / No Excessive Hunger
 Yes / No Excessive Thirst
 Yes / No Dark Stools
 Yes / No Diarrhea
 Yes / No Constipation
 Yes / No Frequent Heartburn
 Yes / No Loss of Appetite

GU

Yes / No Frequent Urination
 Yes / No Burning with Urination
 Yes / No Incontinence of Bladder

Eyes / Ears / Nose / Throat

Yes / No Blurred Vision
 Yes / No Ringing in Ears
 Yes / No Hearing Loss

Ortho

Yes / No Joint Pain
 Yes / No Joint Swelling
 Yes / No Joint Redness
 Yes / No Pain with Walking

Skin

Yes / No Rash
 Yes / No Open Sores
 Yes / No Jaundice

Neuro

Yes / No Dizziness
 Yes / No Memory Change
 Yes / No Light Headedness
 Yes / No Tremor
 Yes / No Weakness
 Yes / No Numbness
 Yes / No Tingling

Endocrine

Yes / No Hair Loss
 Yes / No Excessive Thirst

Family Medical History

Please list any diseases that you have a family history of: _____

Have you or any of your family had problems with anesthesia? No Yes

If yes, please describe _____

Check [x] all of the following that apply.

- [] Employed (occupation _____) [] Work in the home [] Student
- [] Children (number at home _____) [] Live alone
- [] Exercise (times per week _____, what type _____)
- [] Special diet (type _____)
- [] Use tobacco (type _____, #/day _____, how many years _____)
- [] Use alcohol (type _____, #/week _____, how many years _____)
- [] Use street or recreational drugs (type _____)
- [] Ever tested for STD / HIV / AIDS (results: _____)
- [] Blood transfusion (date: ____/____/____)

For women:

Could you be pregnant No Yes Are you breast feeding? No Yes

Start date of last menstrual period ____/____/____

or year of your last menstrual period _____

Patient Signature _____

Date _____

Reviewed by Dr. _____

Date _____