



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Why are we seeing you today? \_\_\_\_\_

**SURGICAL HISTORY**

Procedure	Surgery Date	Notes

**FAMILY HISTORY** Please be specific if it is on the Maternal or Paternal side.

Relation	Problem

Relation	Problem

Any bleeding problems in your family: \_\_\_\_\_

Any problems with anesthesia in your family: \_\_\_\_\_

Family history of blood clots: \_\_\_\_\_

Family History of cancer: \_\_\_\_\_

**MEDICATIONS** If not enough room, please list on back.

Pharmacy: \_\_\_\_\_

Any blood thinners or aspirin. If so, specify: \_\_\_\_\_

Medication/Dosage	Directions

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**ALLERGIES**

Drug/Allergen	Reaction

Drug/Allergen	Reaction

**PAST MEDICAL HISTORY** (ONLY mark if YES)

	Yes	Notes		Yes	Notes
ADHD			Developmental/Behavioral Disorders		
Abdominal Pain			Diabetes		
Abnormal Weight Loss			Dialysis		
Affective Disorders			Diarrhea		
Alcohol Use			Difficulty Swallowing		
Allergies			Digestive Problems		
Anemia			Diverticulitis		
Anorexia			Ear or Hearing Problems		
Anxiety Disorder			Ectopic Pregnancy		
Aortic Aneurysm			Emotional Problems		
Appendicitis			Emphysema		
Appetite, poor			Epilepsy		
Arrhythmia			Fibromyalgia		
Arthritis			Gastrointestinal Disease		
Asthma/Breathing Problems			GERD/ Acid Reflux		
Atrial-Fib			German Measles		
Atrial Flutter			Glaucoma		
Bladder or Kidney Problems			Goiter		
Bleeding Disorder			Gonorrhea		
Bloating			Gout		
Blood Disease			HIV Positive		
Bowel Changes			Headaches or Dizziness		
Breast Mass / Cyst			Heart Attack/ MI (angina)		
Broken Bones			Heart Disease		
Bronchitis			Heart Murmur/ Valve Disorder		
Bulimia			Hemorrhoids		
CVA / Stroke			Hepatitis (Acute or Chronic)		
Cancer			Hernia(s)		
Carotid Disease			High Cholesterol		
Cataracts			Hypertension		
Chemical / Drug Dependency			Hyperthyroidism		
Chicken Pox			Hypothyroidism		
COPD			Incontinence: Fecal		
Chronic Pain			Incontinence: Urinary		
Constipation			Indigestion		
Coronary Artery Disease			Kidney Disease		
Deep Vein Thrombosis			MRSA/ Drug Resistant Infections		
Depression			Measles		

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**PAST MEDICAL HISTORY** (continued)

Migraine Headaches			Pulmonary Embolism		
Miscarriage			Rectal Bleeding		
Mononucleosis			Reflux Disease		
Mouth Sores			Rheumatic Fever		
Multiple Sclerosis			Scarlet Fever		
Mumps			Seizures or Convulsions		
Muscle/ Joint/ Bone Problem			Serious/ Traumatic Injuries		
Nasal Trauma			Sexually Transmitted Disease		
Nausea Alone			Skin Cancer		
Nausea/ Vomiting			Skin Problems		
Organ Transplant			Sleep Apnea (snoring)		
Osteopenia			Suicide Attempt		
Osteoporosis			Shortness of Breath		
Pacemaker			Tonsilitis		
Peptic Ulcers			Tuberculosis		
Peripheral Vascular Problem			Typhoid Fever		
Pneumonia			Ulcers		
Polio			Urinary Tract Infections		
Poliomyelitis			Vaginal Infections		
Post-Menopausal			Vision or Eye Problems		
Prostate Problems			Vomiting Blood		
Psychiatric Care			Other:		

**SOCIAL HISTORY**

Occupation					Notes	
Education					Notes	
Able to Care for self?	Yes		No		Notes	
Alcohol intake	None	Occ	Mod	Heavy	Yrs of use:	
Special Diet (eg: vegan)					Notes	
Exercise level	None	Occ	Mod	Heavy	Notes	
Caffeine intake	None	Occ	Mod	Heavy	Notes	
DNR in place	Yes		No		Notes	
Live alone or with others					Notes	
Illicit Drugs					Yrs of use:	
Recreational Drugs/Products					Yrs of use:	
Stress level	Low	Med		High	Notes	
Sporting Activities					Notes	
Sexually active?	Yes		No		Notes	
Protective sex?	Yes		No		Notes	
Past History of Abuse	Yes		No		Notes	
Current Abuse	Yes		No		Notes	
Type of Abuse	Verbal		Physical	Emotional	Notes	
Smoking Status/ Vaping chewing tobacco	Never	Former	Current Daily	Current Sporadic	Yrs of use:	How much:

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Date of Last Flu Shot: \_\_\_\_\_

Date of Last Pneumonia Vaccine: \_\_\_\_\_

Colon Cancer Screening: Yes:  No:  Date Screened: \_\_\_\_\_

Screen Type:

Colonoscopy  Flexible Sigmoidoscopy  Fecal Occult Blood Testing

Any Polyps or Biopsies done: Yes:  No:  Specify: \_\_\_\_\_

Abnormal Findings: \_\_\_\_\_

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Do you have allergies to any of the following:

- Latex
- Iodine, when: \_\_\_\_\_
- IV Contrast, when: \_\_\_\_\_
- Adhesives, type: \_\_\_\_\_
- No known Allergies