

Patient Name: _____

Date of Birth: _____

MR#: _____

Referring Physician: _____

Height: _____ Weight: _____ Body Mass Index (BMI): _____



YES	NO	PAST MEDICAL HISTORY: (circle any that apply)	YES	NO	PAST MEDICAL HISTORY: (circle any that apply)
_____	_____	heart disease	_____	_____	GI ulcer disease / hiatal hernia / gastric reflux
_____	_____	high blood pressure	_____	_____	IBS / Crohns / ulcerative colitis / diverticulosis
_____	_____	congestive heart failure	_____	_____	kidney disease/stones
_____	_____	heart murmur	_____	_____	hepatitis/tuberculosis / HIV/AIDS
_____	_____	arrhythmia / atrial fibrillation	_____	_____	history of cancer (location: _____)
_____	_____	previous heart attack (MI) or stroke (CVA or TIA)	_____	_____	seizure disorder / neurological disorder
_____	_____	history of blood clot (DVT or PE) / phlebitis / varicose veins	_____	_____	glaucoma
_____	_____	bleeding / clotting disorder	_____	_____	drug use / abuse/addiction
_____	_____	high cholesterol	_____	_____	depression / anxiety / psychiatric illness
_____	_____	obesity / eating disorder	_____	_____	fibromyalgia
_____	_____	diabetes mellitus	_____	_____	osteoarthritis / rheumatoid arthritis / lupus
_____	_____	thyroid disease	_____	_____	osteoporosis / postmenopausal
_____	_____	asthma / emphysema / COPD	_____	_____	seasonal allergies

MEDICATIONS & DOSAGES (including vitamins and herbal supplements): _____

Pharmacy Name and Phone Number: _____

ALLERGIES (medications, foods, iodine, contrast dye, latex, adhesive tape, etc): _____

SOCIAL HISTORY:

Do you smoke tobacco? _____ How many packs? _____ How many years? _____

Do you consume alcohol? _____ How much? _____ How often? _____

Marital status: _____ Are you pregnant? _____ Children? _____

Occupation: _____ Hobbies: _____

YES	NO	FAMILY HISTORY: Has anyone in your family:
_____	_____	Had a tendency to bleed excessively?
_____	_____	Had unusual reactions to anesthesia?
_____	_____	Other significant health problems? Explain: _____

What operations have you had and when?: _____

Please list other hospitalizations and reasons for admission: _____

Primary Medical Provider: _____

YES	NO	REVIEW OF SYSTEMS: (circle all that apply)	YES	NO	REVIEW OF SYSTEMS: (circle all that apply)
_____	_____	constitutional - unexplained fever/weight loss/ night sweats / chills	_____	_____	constipation / diarrhea / bloating
_____	_____	fatigue	_____	_____	blood in stool
_____	_____	muscle / joint pain (location: _____)	_____	_____	abdominal pain
_____	_____	easy bruisability	_____	_____	cough
_____	_____	skin rash	_____	_____	shortness of breath / wheezing
_____	_____	oral ulcers	_____	_____	chest pain / palpitations
_____	_____	visual or hearing changes	_____	_____	urinary frequency / incontinence
_____	_____	headaches	_____	_____	leg edema / swelling
_____	_____	difficulty swallowing	_____	_____	numbness / tingling / weakness (arms or legs)
			_____	_____	other _____

PATIENT SIGNATURE: _____ Date: _____

PHYSICIAN SIGNATURE: _____ Date: _____