

NAME: _____

The reason for my visit:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Past Medical History

Previous Surgeries:

Procedure: _____	Date: _____
Procedure: _____	Date: _____
Procedure: _____	Date: _____
Procedure: _____	Date: _____
Procedure: _____	Date: _____
Procedure: _____	Date: _____

Have you had any unusual problems with anesthetics in the past? If yes, please describe:

Social History

Smoker: No ___ Yes ___ # of packs per day ___
Alcohol: No ___ Yes ___ Average # of drinks per day ___
History of drug addiction: No ___ Yes ___
Place of Birth: _____
Marital Status: _____
Children: ___ Male ___ Female
Education: _____
Occupation: _____

Family History

Did family members have any of the conditions listed below? Please mark the number of conditions next to the appropriate family member. (If deceased please give date of death)

	<u>Condition</u>	<u>Age at time of death</u>		
Father:	_____	_____	1.Cancer	8. Leukemia
Mother:	_____	_____	2. Diabetes	9. Muscle Disease
Brother:	_____	_____		
Sister:	_____	_____	3. Arthritis	10.Kidney Disease
Grandmother:	_____	_____	4. Heart Disease	11. Mental Illness
Grandfather:	_____	_____	5. Hypertension	12.Seizures
			6. Stroke	13. Inherited Problems
			7. Tuberculosis	

(Please only list one)

Medications

Medication Allergies: _____

Prescription Medications

Strength

Dosage

- _____
- _____
- _____
- _____
- _____
- _____

Over the counter medications, nutritional supplements, vitamins, ETC.

- _____
- _____
- _____
- _____
- _____
- _____

Review of Systems:

(Mark those that apply to your condition currently)

- General:** ___Fever ___Weight Loss ___Fatigue ___Special Diet
- Eyes:** ___Visual Loss ___Double Vision ___Injury ___Glasses
___Inflammation ___Glaucoma
- Ears:** ___Deafness ___Ringing ___Dizziness ___Pain in the Ears ___ Discharge
from ears
- Nose:** ___Nose Bleeds ___Obstruction ___Discharge
- Mouth:** ___Soreness mouth or tongue ___Toothache
- Throat:** ___Hoarseness ___Sore Throat ___Voice Changes
- Cardiovascular:** ___Palpitations ___Rapid Heart Beat ___Irregular Heart Beat ___Chest Pain
___Shortness of Breath ___Leg swelling ___Leg Pains While Walking
___High Blood Pressure
- Respiratory:** ___Shortness of Breath ___Wheezing ___Cough ___Bloody Sputum
___Night Sweats ___History of Pleurisy ___Tuberculosis ___Pneumonia
___Asthma
- Gastrointestinal:** ___Nausea ___Abdominal Pain or Colic ___Vomiting ___Vomiting Blood
___Jaundice ___Change in Bowel Habits ___History of Ulcer ___Weight
Loss
- Genitourinary:** ___Urinary Tract Infections ___Painful Urination ___Kidney Stones
___Incontinence ___Blood in your Urine ___ Prostate Cancer Difficulty
Stopping of Starting your Stream
- Musculoskeletal:** ___History of Fractures ___Dislocations ___Sprains ___Neck Pain
___Arthritis ___Muscle Pain ___Stiffness ___Mid-back Pain ___Muscle
Weakness ___Night Cramps ___Joint Swelling ___Low-back Pain
- Integumentary:**
- A.** Skin ___Abnormal Sweating ___Itching ___Rash ___Sores that do not Heal ___Easy
Bruising
- B.** Breast ___Lumps ___Discharge from Nipples ___History of Breast Cancer
- Neurological:** ___Disturbance of Smell ___Facial Numbness ___Difficulty Chewing
___Facial Weakness ___Taste Disturbance ___Hearing Difficulty
___Balance Problems ___Speech Difficulty ___Headaches ___Swallowing
Difficulties ___Paraplegic History ___Loss of Consciousness ___Pain Going
Down Arm ___Pain Going Down Leg ___Involuntary Movement

Seizures/Epilepsy Gait Difficulty Coordination Numbness,
Tingling or Burning Urinary Control Problems Prior Head Injury or
Skull Fractures

Psychiatric: Nervous Breakdown Hallucinations Depression

Endocrine: Abnormal Growth Enlarging Head, Feet, Hands Unusual Hair
Growth Abnormal Change in Skin Color Thyroid or Goiter
Problems Dryness of Hair or Skin Intolerance to Heat
 Intolerance to Cold Excessive Thirst Excessive Urination

Blood & Lymph Systems:
 Anemia Swollen Lymph Nodes Abnormal Bleeding Family
History of Bleeding Disorder

Allergy & Immune System:
 Migraine Food Allergies Aids Immune System Disorder

Women: Are you currently pregnant or think you may be pregnant? Yes No

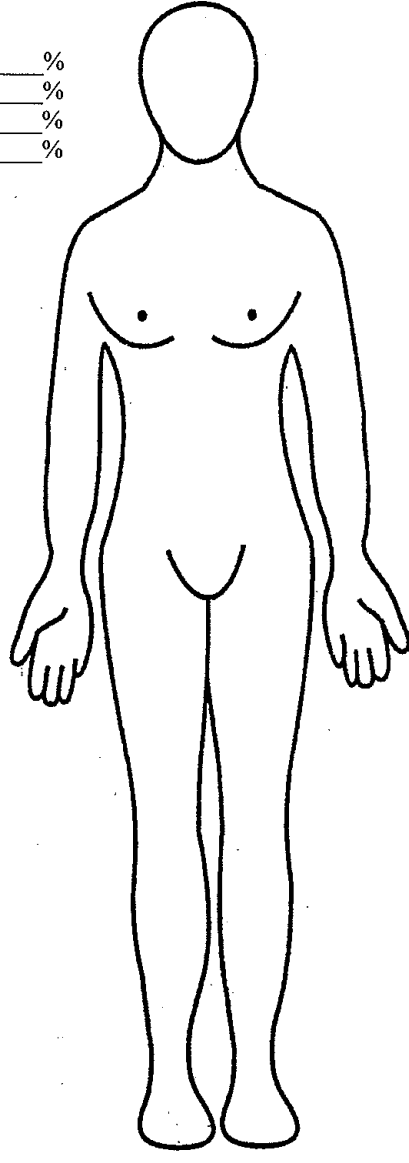
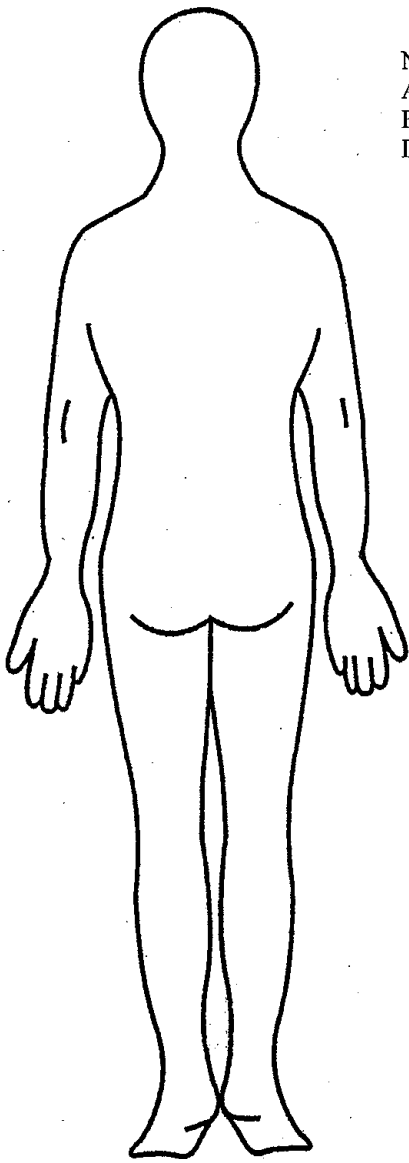
Date: _____ Age: _____ Name: _____

Where is your pain now? (Please complete the pain drawing)

Numbness ===== Pins & Needles ++++++

Burning XXXXXXXXXXXX Stabbing //

Ache ~~~~~ Shooting _____



Neck Pain _____%
Arm Pain _____%
Back Pain _____%
Leg Pain _____%

Pain Level: 0 1 2 3 4 5 6 7 8 9 10

What is your current overall functional activity level?
(working, recreation, household activities, sleeping, etc.)

On a scale from 0 – 100, 0 = Completely Limited 100 = Fully Functional

% 0 10 20 30 40 50 60 70 80 90 100%