

Patient Name _____ Date _____ Account # _____

PAST MEDICAL HISTORY

<p>A. Medical Problems - <input type="checkbox"/> None</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p> <p>6. _____</p> <p>7. _____</p> <p>8. _____</p>	<p>Date _____</p>										
<p>B. Previous Operations/Surgery - <input type="checkbox"/> None</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p> <p>6. _____</p> <p>7. _____</p> <p>8. _____</p>	<p>Date _____</p>										
<p>C. Present medications (including herbal and over-the-counter medications)</p> <p style="text-align: center;"><input type="checkbox"/> None <input type="checkbox"/> See List Provided</p> <table style="width: 100%;"> <tr> <td style="width: 50%;">1. _____</td> <td style="width: 50%;">6. _____</td> </tr> <tr> <td>2. _____</td> <td>7. _____</td> </tr> <tr> <td>3. _____</td> <td>8. _____</td> </tr> <tr> <td>4. _____</td> <td>9. _____</td> </tr> <tr> <td>5. _____</td> <td>10. _____</td> </tr> </table>		1. _____	6. _____	2. _____	7. _____	3. _____	8. _____	4. _____	9. _____	5. _____	10. _____
1. _____	6. _____										
2. _____	7. _____										
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4. _____	9. _____										
5. _____	10. _____										
<p>D. Allergies to Medications <input type="checkbox"/> None Allergy to LATEX <input type="checkbox"/> Yes <input type="checkbox"/> No Reaction: _____</p> <p style="text-align: center;">Dye Allergy <input type="checkbox"/> Yes <input type="checkbox"/> No Reaction: _____</p> <table style="width: 100%;"> <tr> <td style="width: 50%;">1. _____</td> <td style="width: 50%;">Reaction: _____</td> </tr> <tr> <td>2. _____</td> <td>Reaction: _____</td> </tr> <tr> <td>3. _____</td> <td>Reaction: _____</td> </tr> <tr> <td>4. _____</td> <td>Reaction: _____</td> </tr> </table>		1. _____	Reaction: _____	2. _____	Reaction: _____	3. _____	Reaction: _____	4. _____	Reaction: _____		
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2. _____	Reaction: _____										
3. _____	Reaction: _____										
4. _____	Reaction: _____										
<p>E. Social History:</p> <p>Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed</p> <p>Number of pregnancies _____ Number of children _____</p> <p>Occupation _____</p> <p>Do you smoke: <input type="checkbox"/> Yes <input type="checkbox"/> No Packs per day _____ Years _____</p> <p>Alcohol use: <input type="checkbox"/> None <input type="checkbox"/> Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily</p>											
<p>F. Family Medical History (parents, siblings, children, etc.):</p> <p>List all family members and type of problem</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Cancer _____</td> <td><input type="checkbox"/> Stroke _____</td> </tr> <tr> <td><input type="checkbox"/> Diabetes _____</td> <td><input type="checkbox"/> Anesthesia problems _____</td> </tr> <tr> <td><input type="checkbox"/> Heart disease _____</td> <td><input type="checkbox"/> Bleeding problems _____</td> </tr> <tr> <td><input type="checkbox"/> Hypertension _____</td> <td></td> </tr> </table>		<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Anesthesia problems _____	<input type="checkbox"/> Heart disease _____	<input type="checkbox"/> Bleeding problems _____	<input type="checkbox"/> Hypertension _____			
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<input type="checkbox"/> Heart disease _____	<input type="checkbox"/> Bleeding problems _____										
<input type="checkbox"/> Hypertension _____											

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Review of Systems: Please indicate any personal history below:

CONSTITUTIONAL SYMPTOMS

Fatigue/malaise..... Yes No
Fever/night sweats..... Yes No
Recent weight change..... Yes No
Describe: _____

EYES

Wear glasses/contacts..... Yes No
Glaucoma..... Yes No
Cataracts..... Yes No

EARS/NOSE/THROAT

Hearing loss or ringing..... Yes No
Chronic sinus problems..... Yes No
Sore throat or voice change.... Yes No

CARDIOVASCULAR

Heart disease..... Yes No
Chest pain or angina pectoris..... Yes No
Shortness of breath with exercise... Yes No

RESPIRATORY

Chronic or frequent coughs..... Yes No
Shortness of breath..... Yes No
Asthma or wheezing..... Yes No
Sleep apnea..... Yes No

GASTROINTESTINAL

Loss of appetite..... Yes No
Nausea or vomiting..... Yes No
Abdominal pain..... Yes No
Change in bowel movements... Yes No
Frequent diarrhea..... Yes No
Frequent constipation..... Yes No
Rectal bleeding or blood in stool.. Yes No
Ulcer..... Yes No
Date of last colonoscopy _____
Comments _____

GENITOURINARY

Frequent urination..... Yes No
Burning or painful urination... Yes No
Blood in urine..... Yes No
Kidney stones..... Yes No
Kidney disease..... Yes No

Additional Comments: _____

Completed Date and Patient Initials: _____

Review Date/M.D. Initials: _____

MUSCULOSKELETAL

Joint stiffness or swelling..... Yes No
Muscle weakness..... Yes No
Muscle pain or cramps..... Yes No
Back pain..... Yes No

INTEGUMENTARY

(skin, breast)
Varicose veins..... Yes No
Breast pain..... Yes No
Breast discharge..... Yes No
Date of last mammogram: _____

NEUROLOGICAL

Frequent or recurring headaches.. Yes No
Convulsion or seizures..... Yes No
Numbness or tingling sensation... Yes No
Memory problems..... Yes No

PSYCHIATRIC

Depression..... Yes No
Psychiatric illness..... Yes No
Describe _____

ENDOCRINE

Thyroid disease..... Yes No
Heat/cold intolerance..... Yes No
Diabetes..... Yes No
A) Do you use insulin to treat your diabetes.. Yes No

HEMATOLOGIC/LYMPHATIC

Bleeding or bruising tendency... Yes No
Anemia..... Yes No
Blood clots..... Yes No
Reaction to blood transfusion.... Yes No
Describe _____

FOR DIALYSIS PATIENTS:

M T W TH F S SU

Time: _____
Dialysis Unit: _____
Phone Number: () _____
Dialysis Doctor: _____