



Patient Height: ___feet ___inches Patient Weight: _____ lbs

Activities (ie Running, surfing, swimming, basketball, golf, etc...) _____

MEDICAL HISTORY: Please check if **you** have any of the following:

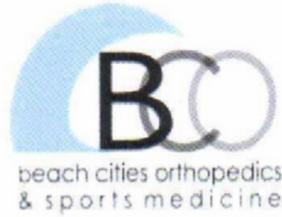
- | | | | | | |
|---------------------|--------------------------|----------|--------------------------|----------------------|--------------------------|
| High blood pressure | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| Heart disease | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> |
| Bleeding problems | <input type="checkbox"/> | | | | |

OTHER MEDICAL PROBLEMS (List/specify) _____

Past hospitalizations/surgeries/injuries and approximate dates: _____

Allergies (Medication or Latex) (List) _____

Current Medications:



FAMILY HISTORY:

Please check if any of your relatives ever had any of the following problems- indicate who:

- | | | | |
|---------------|-------------------------------------|---------------------|-------------------------------------|
| Heart disease | <input type="checkbox"/> Who: _____ | High blood pressure | <input type="checkbox"/> Who: _____ |
| Diabetes | <input type="checkbox"/> Who: _____ | Stroke | <input type="checkbox"/> Who: _____ |
| Cancer | <input type="checkbox"/> Who: _____ | Thyroid disease | <input type="checkbox"/> Who: _____ |

SOCIAL HISTORY:

- Marital status: single married separated divorced widowed
- Tobacco use: never quit-when _____ smoker/pack per day _____
- Alcohol use: never rarely moderate daily
- Drug use: never type and frequency _____

REVIEW OF SYSTEMS (Check all that apply to you)

Constitutional

- Good General Health
- Recent weight change
- Night sweats, fevers
- Fatigue

Cardiovascular

- Chest pain
- Palpitations
- Heart trouble
- Swelling hands/feet

Musculoskeletal

- Muscle pain or cramps
- Stiffness/swelling in joints
- Joint pain
- Trouble walking

Endocrine

- Excessive thirst/urination
- Thyroid disease
- Hormone problem

Genitourinary – Male only

- Blood in urine
- Kidney stones
- Sexual problems
- Testicle pain

Ears/Nose/Mouth/Throat

- Hearing loss or ringing
- Sinus problems
- Nose bleeds
- Sore throat/voice change

Respiratory

- Shortness of breath
- Cough
- Wheezing/asthma
- Coughing up blood

Neurological

- Frequent headaches
- Paralysis or tremors
- Convulsions/seizures
- Numbness/tingling

Hematologic/Lymphatic

- Bruise easily
- Slow to heal
- Enlarged glands

Genitourinary-Female only

- Blood in urine
- Kidney stones
- Sexual problems
- Menstrual pain

Eyes

- Wear glasses/contacts
- Blurred/double vision
- Eye disease or injury
- Glaucoma

Gastrointestinal

- Nausea/vomiting
- Abdominal Pain
- Rectal Bleeding
- Bowel problems

Integumentary (Skin/Breast)

- Change in hair/nails
- Rashes or itching
- Breast lump
- Breast pain or discharge

Allergic/Immunologic

- Food allergies
- Aspirin allergies
- Antibiotic allergies

Psychiatric

- Insomnia
- Confusion/memory loss
- Depression

Patient Statement: To the best of my knowledge, the above information is accurate.

Signed: _____ Date: _____

Physician Statement: I have reviewed the questionnaire with the patient.

Signed: _____ Date: _____