**RAYMOND D. FULLER, M.D.**
**KENNETH C. GRAFFEO, M.D.**
**MICHELLE J. WOOD, D.O.**

Patient:

DOB:

Please complete the following questions regarding your allergies, medications, family history and past medical history:

| ALLERGIES TO MEDICATIONS? | ____NONE |
|---|---|
| **Drug Name** | **Reaction** |
| | |
| | |
| | |
| | |
| | |

| MEDICATIONS | ____NONE |
|---|---|
| **Drug Name** | **Dose & Frequency** |
| | |
| | |
| | |
| | |
| | |

| LIFESTYLE | |
|---|---|
| M S D W | **MARITAL STATUS** |
| Y N | **SMOKING** |
| | ____packs/day for ____ years |
| | Quit ____ years ago |
| Y N | **ALCOHOL USE** |
| | ____drinks/day for ____ years |
| | Quit ____ years ago |

| WOMEN'S HEALTH | |
|---|---|
| Y N | Birth Control – Type: |
| _____ | Menstrual Period |
| _____ | Date of Last Pap Smear |
| _____ | Date of Last Mammogram |
| _____ | Number of Pregnancies |
| _____ | Number of Live Births |

MEDICAL HISTORY

| **GENERAL** | **INTESTINAL** | **UROLOGY/ GYN** |
|---|---|---|
| Y N Blood Clots | Y N Ulcers | Y N Kidney Stones |
| Y N Bleeding Disorder | Y N Esophageal Reflux | Y N Other Kidney Problem |
| Y N Diabetes | Y N Hiatal Hernia | Y N Prostate Problem |
| Y N Thyroid Disorder | Y N Diverticulitis | Y N Prostate Cancer |
| Y N Blood Transfusion | Y N Irritable Bowel | Y N Vaginal Bleeding |
| Y N Seizures | Y N Crohn's Disease | Y N Ovarian Cancer |
| **HEART** | Y N Colon Polyps | Y N Cervix/Uterine Cancer |
| Y N High Blood Pressure | Y N Hepatitis | **CIRCULATION** |
| Y N Angina | Y N Hemorrhoids | Y N Stroke/TIA's |
| Y N Heart Attack | Y N Anal Fissure | Y N Aneurysm |
| Y N Heart Failure | Y N Colon Cancer | Y N Claudication |
| Y N Murmur/Valve Disease | Y N Stomach Cancer | |
| | Y N Esophageal Cancer | |

| **LUNGS** | **BREAST** | **SKIN, JOINTS & MUSCLES** |
|---|---|---|
| Y N Asthma | Y N Fibrocystic disease | Y N Skin Cancer |
| Y N COPD | Y N Mastitis | Y N Arthritis |
| Y N Lung Cancer | Y N Breast Cancer | Y N Fibromyalgia |
| | | Y N Low Back Pain |

OTHER MEDICAL PROBLEMS:

COMPLETE NEXT PAGE

## PAST SURGICAL HISTORY

### ANESTHESIA

Y N General Anesthesia
Y N Spinal/Epidural

### HEAD & NECK

Y N Tonsillectomy
Y N Thyroid Surgery

### HEART

Y N Heart Catheterization
Y N Angioplasty
Y N Coronary Bypass
Y N Valve Replacement
Y N Pacemaker
Y N Defibrillator

### LUNGS

Y N Bronchoscopy
Y N Lung Biopsy
Y N Lung Resection

### INTESTINAL

Y N Upper Endoscopy
Y N Colonoscopy
Y N Appendectomy
Y N Gallbladder
Y N Ulcer Surgery
Y N Colon Resection
Y N Reflux Surgery
Y N Adhesions
Y N Groin hernia
Y N Incisional hernia

### BREAST

Y N Breast Biopsy
Y N Lumpectomy

### UROLOGY/GYN

Y N Tubal Ligation
Y N C-section
Y N Hysterectomy

### CIRCULATION

Y N Carotid Surgery
Y N Aortic Surgery

### SKIN, JOINTS & MUSCLES

Y N Arthroscopy
Y N Fracture Surgery
Y N Joint Replacement
Y N Back Surgery

### OTHER SURGICAL PROCEDURES:

## FAMILY HISTORY

Y N Diabetes
Y N Heart Disease
Y N High Blood Pressure
Y N Stroke
Y N Asthma
Y N Blood Clots
Y N Bleeding Disorders
Y N Thyroid Problems
Y N Breast Cancer
Y N Colon Cancer
Y N Other Cancer
Y N Mental Illness

### OTHER DISEASES THAT RUN IN FAMILY:

## OTHER CURRENT HEALTH ISSUES OR CONCERNS

Y N Fevers
Y N Weight Loss
Y N Chest Pains
Y N Short of Breath
Y N Visual Problems
Y N Sore Throat
Y N Cough
Y N Leg Swelling
Y N Abdominal Pain
Y N Nausea
Y N Vomiting
Y N Loss of Appetite
Y N Constipation
Y N Diarrhea
Y N Urinary Problems
Y N Skin Problems
Y N Depression/Anxiety
Y N Headaches
Y N Dizziness
Y N Breast Problems
Y N Vaginal Discharge
Y N Blood in Stool
Y N Joint Pain

## ADDITIONAL INFORMATION

Physician Signature Date