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Patient:

DOB:

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

<b>ALLERGIES TO MEDICATIONS?</b>		___NONE	<b>LIFESTYLE</b>	
<b>Drug Name</b>	<b>Reaction</b>		M S D W	<b>MARITAL STATUS</b>
			Y N	<b>SMOKING</b>
				___packs/day for ___ years
				Quit ___ years ago
			Y N	<b>ALCOHOL USE</b>
				___drinks/day for ___ years
				Quit ___ years ago
<b>MEDICATIONS</b>		___NONE	<b>WOMEN'S HEALTH</b>	
<b>Drug Name</b>	<b>Dose &amp; Frequency</b>		Y N	Birth Control – Type:
				Menstrual Period
				Date of Last Pap Smear
				Date of Last Mammogram
				Number of Pregnancies
				Number of Live Births
<b>MEDICAL HISTORY</b>				
<b>GENERAL</b>		<b>INTESTINAL</b>		<b>UROLOGY/ GYN</b>
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
		Y N Colon Polyps		Y N Cervix/Uterine Cancer
		Y N Hepatitis		<b>CIRCULATION</b>
<b>HEART</b>		Y N Hemorrhoids		Y N Stroke/TIA's
Y N High Blood Pressure		Y N Anal Fissure		Y N Aneurysm
Y N Angina		Y N Colon Cancer		Y N Claudication
Y N Heart Attack		Y N Stomach Cancer		
Y N Heart Failure		Y N Esophageal Cancer		
Y N Murmur/Valve Disease				
<b>LUNGS</b>		<b>BREAST</b>		<b>SKIN, JOINTS &amp; MUSCLES</b>
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: \_\_\_\_\_

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PAST SURGICAL HISTORY		
<b>ANESTHESIA</b>	<b>INTESTINAL</b>	<b>UROLOGY/GYN</b>
Y N General Anesthesia Y N Spinal/Epidural	Y N Upper Endoscopy Y N Colonoscopy Y N Appendectomy Y N Gallbladder	Y N Tubal Ligation Y N C-section Y N Hysterectomy
<b>HEAD &amp; NECK</b>	Y N Ulcer Surgery Y N Colon Resection Y N Reflux Surgery Y N Adhesions	<b>CIRCULATION</b>
Y N Tonsillectomy Y N Thyroid Surgery	Y N Groin hernia Y N Incisional hernia	Y N Carotid Surgery Y N Aortic Surgery
<b>HEART</b>	<b>BREAST</b>	<b>SKIN, JOINTS &amp; MUSCLES</b>
Y N Heart Catheterization Y N Angioplasty Y N Coronary Bypass Y N Valve Replacement Y N Pacemaker Y N Defibrillator	Y N Breast Biopsy Y N Lumpectomy	Y N Arthroscopy Y N Fracture Surgery Y N Joint Replacement Y N Back Surgery
<b>LUNGS</b>	<b>OTHER SURGICAL PROCEDURES:</b>	
Y N Bronchoscopy Y N Lung Biopsy Y N Lung Resection		

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