

Name: _____ Birth date: _____ Age: _____

Primary Care Physician: _____ None

Who referred you? My Physician Another Physician, if so who? _____
 Self Friend

How can we help you? (Chief Complaint)

Do you have any medication allergies? NO Yes—please list medication allergy

Is there any family history of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anesthesia problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Disease | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Loss | |

Do you take any of the following medications?

- | | | |
|---|---|------------------------------------|
| <input type="checkbox"/> Aggrenox | <input type="checkbox"/> Gingko biloba | <input type="checkbox"/> Ticlid |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Ibuprofen or other NSAID | <input type="checkbox"/> Vitamin E |
| <input type="checkbox"/> Coumadin or warfarin | <input type="checkbox"/> Plavix | |
| <input type="checkbox"/> Garlic | | |

OTHER _____

Do you have any of the following health problems? (Check all that apply) (PMH)

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head injury | <input type="checkbox"/> Prostate Enlargement |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bowel Disease | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure (HTN) | <input type="checkbox"/> Vision Impairment |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Esophageal Reflux | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Glaucoma | | |
| <input type="checkbox"/> Cataracts | | |

I HAVE NONE OF THE ABOVE

Other Health Problems: _____

For Women: Is there any chance you could be pregnant? Yes No

When was your last menstrual period: _____

PLEASE COMPLETE THE OTHER SIDE ➔

Do you have any of the following symptoms? (ROS)

- | | | |
|---|--|--|
| <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Passing out |
| <input type="checkbox"/> Burning with urination | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Headache | <input type="checkbox"/> Skin lesions |
| <input type="checkbox"/> Constipation or Diarrhea | <input type="checkbox"/> Heat/cold intolerance | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Nausea/vomiting | |
| | <input type="checkbox"/> Palpitations | |

Have you had any of the following surgeries? (Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Abdominal surgery | <input type="checkbox"/> Hip surgery | <input type="checkbox"/> Other orthopedic surgery |
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Prostate surgery |
| <input type="checkbox"/> Aneurysm Surgery | <input type="checkbox"/> Knee surgery | <input type="checkbox"/> Septal surgery |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Sinus surgery |
| <input type="checkbox"/> Bladder surgery | <input type="checkbox"/> Lung surgery | <input type="checkbox"/> Stent placement |
| <input type="checkbox"/> Bypass surgery | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Stomach surgery |
| <input type="checkbox"/> C-section | <input type="checkbox"/> Mastoidectomy | <input type="checkbox"/> Thyroid surgery |
| <input type="checkbox"/> Ear tubes | <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Eye surgery | <input type="checkbox"/> Other Ear, Nose or Throat surgery | <input type="checkbox"/> Tooth extraction |
| <input type="checkbox"/> Gall bladder | <input type="checkbox"/> Other heart surgery | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> Heart valve surgery | | |
| <input type="checkbox"/> Hernia | | |

I HAVE NEVER HAD SURGERY

ADULTS:

(Social Hx)

- Do you drink alcohol? Yes No If so, how much per week? _____
- Do you use caffeine products? Yes No Type: _____ Weekly Amount: _____
- Is there chemical exposure? Yes No
- Do you, or have you used recreational drugs? Yes No Type: _____
- Is there noise exposure? Yes No
- Do you have pets in the home? Yes No If so, what type? _____
- Do you now use tobacco products? Yes No In the past? Yes No
If so, what kind? _____ How much? _____ How many years? _____
- Have you ever quit? Yes No When? _____
- Does anyone smoke in the home? Yes No
- Occupation: _____

CHILDREN:

- Is your child in day care or school? Yes No
- Do you have pets in the home? Yes No If so, what type? _____
- Is anyone in the home a smoker? Yes No
- Are cigarettes used in the home or car? Yes No
- Is your child meeting his/her developmental milestones? Yes No
- If in school, is your child doing well? Yes No

Who are the legal guardians?

By signing below, I certify that to the best of my knowledge, the above information is complete and accurate.

Patient/Guardian Signature: _____ **Date:** _____

Physician Reviewed: _____ **Date:** _____