Name: DOB:

Surgical History (Please circle any operations you have had):

Gallbladder	Plastic Surgery	Thyroid
Hernia	Joint Replacement	Heart Surgery
Colon	Back Surgery	Pacemaker
Prostate	Cataracts	Appendectomy

Other operations:

Were there bleeding or anesthetic complications with any of your operations? If yes, please explain:

Past or Present Medical Problems (Circle any that you currently have or have had in the past):

Diabetes	Anemia	Irregular Heart Rate	Fibromyalgia	HIV/AIDS
Stroke	Seizures	Hepatitis (A,B, or C)	High Blood Pressure	Stomach Ulcers
Heart Condition	GERD	Heart Attack	Thyroid Problems	Emphysema/Asthma
Depression	High Cholesterol	Migraines		

Other Medical Conditions:

Do you smoke? Yes ☐ No ☐ **Packs per day:**_____ **How many years?:**_____

Do you drink alcohol? Yes ☐ No ☐ **If yes, how often? Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐**

Please list all medications that you are currently on: _____

_____

_____

Please list all allergies that you have:_____

_____

_____

Name: DOB:

Review of Symptoms

Do you NOW HAVE any problems related to the following body systems? Please circle YES or NO and explain and YES answers in the space provided.

General Symptoms:				**Musculoskeletal:**			
Fever	Yes	No		Joint Pain	Yes	No	
Chills	Yes	No		Neck Pain	Yes	No	
Weight Loss	Yes	No		Back Pain	Yes	No	
Skin Rashes	Yes	No		Arthritis	Yes	No	
Skin Infections	Yes	No					
Neurologic:				**Ear/Nose/Throat:**			
Tremors	Yes	No		Infection	Yes	No	
Dizziness	Yes	No		Sinus Problem	Yes	No	
Numbness	Yes	No		Snoring	Yes	No	
				Blurring Vision	Yes	No	
				Blindness	Yes	No	
Gastrointestinal:				**Respiratory:**			
Abdomen Pain	Yes	No		Wheezing	Yes	No	
Nausea/Vomiting	Yes	No		Persistent cough	Yes	No	
Diarrhea/Constipation	Yes	No		Short of breath	Yes	No	
Heartburn	Yes	No		Winded easily	Yes	No	
Appetite Loss	Yes	No		On Oxygen	Yes	No	
Bloody Stool	Yes	No					
Heart:				**Blood:**			
Chest Pain	Yes	No		Easy Bruising	Yes	No	
Palpitations	Yes	No		Bleeding	Yes	No	
Passing Out	Yes	No		Blood Clots	Yes	No	
	Yes	No		Swollen Glands	Yes	No	
Psychological:				**Urinary:**			
Are you satisfied with life?	Yes	No		Incontinence	Yes	No	
Are you depressed?	Yes	No		Painful	Yes	No	
Have you ever been suicidal?	Yes	No		Frequency	Yes	No	
				Difficulty	Yes	No	

Physician Use (Comments/Notes):

Physician's Signature:_____ **Date:**_____