

ALL INFORMATION IS IMPORTANT PLEASE COMPLETE ALL SECTIONS

DRUG ALLERGY LIST Please check/list all medications or vaccinations that have caused an allergic reaction in the past:

- Penicillin
 Sulfa Drugs
 IV/Dye
 Novacaine/Lidocaine
 Codeine
 No Known Drug Allergies
 Other, Please List

LATEX ALLERGY? Are you allergic to latex? Yes No

ANESTHESIA PROBLEMS? Have you had any previous difficulties with general anesthesia or sedation? Yes No If yes, please provide detail below

PREGNANCY? Are you currently pregnant? Yes No Possibly

FAMILY HISTORY Check if any of your blood relatives have had any of the following conditions:

	Indicate Relationship to You(Maternal or Paternal)		Indicate Relationship to You
<input type="checkbox"/> Stroke		<input type="checkbox"/> Ischemic Heart Disease	
<input type="checkbox"/> Breast Cancer		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Colon Cancer		<input type="checkbox"/> Ovarian Cancer	
<input type="checkbox"/> Colon Polyps		<input type="checkbox"/> Regional Enteritis (Crohn's Disease)	
<input type="checkbox"/> Diabetes Mellitus		<input type="checkbox"/> Thyroid Cancer	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	

SOCIAL HISTORY Check which substances you use and how much you use:

<input type="checkbox"/> Alcohol, no use	<input type="checkbox"/> Alcohol, heavy use	<input type="checkbox"/> Tobacco, 1 ppd	<input type="checkbox"/> Other
<input type="checkbox"/> Tobacco, no use	<input type="checkbox"/> Chewing Tobacco	<input type="checkbox"/> Tobacco, 1.5 ppd	
<input type="checkbox"/> Alcohol, rare use	<input type="checkbox"/> Tobacco, former smoker ____Yrs	<input type="checkbox"/> Tobacco, 2.0 ppd	<input type="checkbox"/> Illegal Drugs, specify:
<input type="checkbox"/> Alcohol, moderate use	<input type="checkbox"/> Tobacco, ½ ppd	<input type="checkbox"/> Tobacco, > 2 ppd	

REVIEW OF SYSTEMS Check symptoms you CURRENTLY have or ARE ASSOCIATED WITH THE REASON FOR YOUR VISIT.

<p>GENERAL</p> <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Malaise <input type="checkbox"/> Body Aches <input type="checkbox"/> Night Sweats <input type="checkbox"/> Other: _____ <p>EYES</p> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Impaired Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Eye Pain <input type="checkbox"/> Other: _____ <p>Head, Ear, Nose, Throat</p> <input type="checkbox"/> Sore Throat <input type="checkbox"/> Headaches <input type="checkbox"/> Vertigo (dizziness) <input type="checkbox"/> Lightheaded <input type="checkbox"/> Dental Problems <input type="checkbox"/> Dentures <input type="checkbox"/> Neck Pain <input type="checkbox"/> Thyroid Mass <input type="checkbox"/> Recent Head Injury <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Other: _____	<p>BREASTS</p> <input type="checkbox"/> Lumps <input type="checkbox"/> Tenderness <input type="checkbox"/> Swelling <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Rash/Scaling <input type="checkbox"/> Nipple Retraction <input type="checkbox"/> Other: _____ <p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Rapid Heart Rate <input type="checkbox"/> Shortness of Breath w/ exercise <input type="checkbox"/> Shortness of Breath when lying down <input type="checkbox"/> Episodes of unconsciousness <input type="checkbox"/> Shortness of Breath at nighttime <input type="checkbox"/> Lower extremity swelling <input type="checkbox"/> Lower extremity blueness <input type="checkbox"/> Varicose veins <input type="checkbox"/> Venous cords <input type="checkbox"/> Leg pain with walking <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Dizziness when standing <input type="checkbox"/> Other: _____	<p>RESPIRATORY</p> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough <input type="checkbox"/> Hoarseness <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Anesthetic Problems <p>GASTROINTESTINAL</p> <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Feel full after eating small amounts of food <input type="checkbox"/> Heartburn <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Painful Swallowing <input type="checkbox"/> Vomiting Blood <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Bloating <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Jaundice-yellow skin, eyes <input type="checkbox"/> Blood in stool <input type="checkbox"/> Black, tarry stool <input type="checkbox"/> Other: _____ <p>GENITOURINARY</p> <input type="checkbox"/> Urgency <input type="checkbox"/> Frequency <input type="checkbox"/> Painful Urination	<p>GENITOURINARY</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Urinary retention <input type="checkbox"/> Difficulty voiding <input type="checkbox"/> Urinary hesitancy <input type="checkbox"/> Irregular period <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Possible pregnancy <input type="checkbox"/> Scrotal mass <input type="checkbox"/> Other: _____ <p>SKIN</p> <input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> New Skin Lesions <input type="checkbox"/> Changes to Skin Lesions <input type="checkbox"/> Other: _____ <p>NEUROLOGIC</p> <input type="checkbox"/> Tingling or numbness <input type="checkbox"/> Weakness <input type="checkbox"/> Poor coordination <input type="checkbox"/> Speech difficulties <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Other: _____ <p>MUSCULOSKELETAL</p> <input type="checkbox"/> Bone Pain <input type="checkbox"/> Back Pain <input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Pain	<p>MUSCULOSKELETAL</p> <input type="checkbox"/> Limitation of Motion <input type="checkbox"/> Muscular Weakness <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Other: _____ <p>ENDOCRINE</p> <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Other: _____ <p>PSYCHIATRIC</p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Hallucinations <input type="checkbox"/> Other: _____ <p>HEME-LYMPH</p> <input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy bruising <input type="checkbox"/> Tiny red spots on skin <input type="checkbox"/> Purple areas on skin <input type="checkbox"/> Lymph node swelling <input type="checkbox"/> Other: _____ <p>ALLERGIC/IMMUNOLOGIC</p> <input type="checkbox"/> Sinus Allergies <input type="checkbox"/> Allergic dermatitis <input type="checkbox"/> Frequent Infections <input type="checkbox"/> Other: _____
--	--	---	---	--