



## ALLERGY LIST

Are you allergic to latex?  Yes  No

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

Please list all medications or vaccinations that have caused an allergic reaction in the past:

## FAMILY HISTORY

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

	Indicate Relationship to You		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"/> Tobacco, > 2 ppd
<input type="checkbox"/> Alcohol, rare use	<input type="checkbox"/> Tobacco, former smoker	<input type="checkbox"/> Tobacco, 1.5 ppd	<input type="checkbox"/> Illegal Drugs, specify:
<input type="checkbox"/> Alcohol, moderate use	<input type="checkbox"/> Tobacco, ½ ppd	<input type="checkbox"/> Tobacco, 2.0 ppd	

## REVIEW OF SYSTEMS

 Check symptoms you **CURRENTLY** have or **ARE ASSOCIATED WITH THE REASON FOR YOUR VISIT**.

<b>GENERAL</b> <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: _____	<b>BREASTS</b> <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: _____	<b>RESPIRATORY</b> <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	<b>GENITOURINARY</b> <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: _____	<b>MUSCULOSKELETAL</b> <input type="checkbox"/> Limitation of Motion <input type="checkbox"/> Muscular Weakness <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Other: _____
<b>EYES</b> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Impaired Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Eye Pain <input type="checkbox"/> Other: _____	<b>CARDIOVASCULAR</b> <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: _____	<b>GASTROINTESTINAL</b> <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: _____	<b>SKIN</b> <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: _____	<b>ENDOCRINE</b> <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: _____
<b>Head, Ear, Nose, Throat</b> <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 checked="" type="checkbox"/> <b>Hearing Loss</b> <input type="checkbox"/> Other: _____	<b>GENITOURINARY</b> <input type="checkbox"/> Urgency <input type="checkbox"/> Frequency <input type="checkbox"/> Painful Urination	<b>NEUROLOGIC</b> <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: _____	<b>MUSCULOSKELETAL</b> <input type="checkbox"/> Bone Pain <input type="checkbox"/> Back Pain <input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Pain	<b>PSYCHIATRIC</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Hallucinations <input type="checkbox"/> Other: _____
				<b>HEME-LYMPH</b> <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: _____
				<b>ALLERGIC/IMMUNOLOGIC</b> <input type="checkbox"/> Sinus Allergies <input type="checkbox"/> Allergic dermatitis <input type="checkbox"/> Frequent Infections <input type="checkbox"/> Other: _____