

Name: _____ Today's Date: _____

ALLERGIES:

Is your tetanus immunization up to date? Yes__ No__ Unknown_____

HOSPITALIZATIONS AND SURGERIES

Non surgical hospitalizations	Year	Complications

Surgeries	Year	Complications

Have you ever had general anesthesia? No__ Yes__
 Have you had any problems with anesthesia? No__ Yes__ Describe: _____

FAMILY HISTORY

Member	Alive	Deceased	Age	Health Status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister//Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Name: _____ Today's Date: _____

SOCIAL HISTORY

Work status: Work in the home Employed (occupation _____) Student
 Retired (from what profession/job _____)

Marital status Single Married Divorced Separated Widowed

Children? No Yes # _____

Do you live alone? No Yes

Exercise? Daily Weekly Monthly Rarely Never

What type if exercises? _____

History of substance abuse? _____

Smoke currently? No Yes What? _____ How much? _____

Quit smoking? This year >1years >5 years >10 years

Previously smoked _____ packs per day for _____ years.

Drink alcohol? Daily 1-2 x/week 1-2 x/month 1-2 x/year

REVIEW OF SYSTEMS

Are you currently having trouble with your:

	Circle	Describe all Yes responses
Eyes	No Yes	_____
Ears, Nose, Throat	No Yes	_____
Lungs, Breathing	No Yes	_____
High blood pressure	No Yes	_____
Heart	No Yes	_____
Chest pain	No Yes	_____
Swelling of your feet	No Yes	_____
Digestion	No Yes	_____
Bowel movement	No Yes	_____
Kidneys	No Yes	_____
Bladder	No Yes	_____
Bleeding problems	No Yes	_____
Balance problems	No Yes	_____
Numbness/tingling	No Yes	_____
Blackout/Fainting	No Yes	_____
Psychological problems	No Yes	_____

Patient Signature: _____ Date: _____

Review with the patient by: _____ MD Date: _____