

PATIENT NAME: _____ **Today's Date:** ____/____/____

Reason for appointment: _____ Referring Doctor: _____

List previous surgeries: _____

Other medical problems & hospital stays (not including pregnancies) _____

Medications: _____

Allergies to Medications (please specify problem): _____

Blood relatives with the following diseases (cancer ~ please indicate type of cancer ~ heart problems, blood pressure or diabetes): _____

Who may we contact outside of your home in case of an emergency?

Name:	Relationship:	Phone Number:
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Do you smoke: Y N If yes, how many packs per day? _____ Did you quit smoking? _____

Do you consume alcohol? Y N If yes, how many drinks per day? _____

Do you use or have you ever used street drugs? Y N If yes, which drugs? _____

Please check if you have/had problems related to the areas indicated:

	Yes	No		Yes	No		Yes	No
Constitutional			Endocrine System			Gastrointestinal		
Weight change			Diabetes			Reflux		
Fevers			Thyroid problem			Hepatitis		
Sweats			Hormone treatment			Blood in stools		
Fatigue			Breast			Constipation		
Eyes			Previous breast biopsies			Diarrhea		
Glaucoma			Breast lump(s)			Difficulty swallowing		
Cataracts			Discharge			Jaundice		
Vision surgery			Pain			Pain on bowel movement		
Ears, Nose, Throat			Urinary System			Incontinence		
Loss of hearing			Urinary tract/bladder infections			Hernia?		
Dizziness			Kidney stones			Musculoskeletal		
Nose bleeding			Prostate problems			Osteoarthritis		
Respiratory			Incontinence			Rheumatoid		
Pneumonia			Skin			Gout		
Asthma/Wheezing			Cancers			Infectious Disease		
Shortness breath			Rashes			Tuberculosis		
Sleep apnea			Neurologic			Hepatitis		
Bronchitis			Stroke			HIV/AIDS		
Cardiovascular			Seizures			Psychiatric		
Chest pain			Head injury			Depression		
Heart murmur						Anxiety		
Varicose veins						<i>Following questions for women....</i>		
Leg pain walking						Age at first period		
Transfusions						Still having periods		
Phlebitis/blood clot						Did you breastfeed		
Rheumatic fever						Are you currently pregnant?		

The information provided in this form is true and complete to the best of my knowledge.

Patient signature: _____ Date: ____/____/____

Form reviewed by physician: _____ Date: ____/____/____