

Today's Date: _____ Birthdate: _____ Age: _____

Patient's Name: _____

Reason for your visit today: _____

Family Physician's Name: _____ Date of Last Physical Exam: _____

Referring Physician if different then above: _____

DRUG ALLERGIES: _____

MEDICATIONS (*currently taking*): _____

PAST SURGERIES: _____

ANESTHESIA PROBLEMS IN THE PAST? No Yes – what _____

FAMILY ANESTHESIA PROBLEMS IN THE PAST? No Yes – what _____

HOSPITALIZATION FOR ILLNESS (*include date and problem*): _____

If patient is a child, do they attend a daycare? _____

Weight: Current _____ One year ago _____ Maximum _____ – when _____

Do you smoke? No Yes – how much _____ how long _____

When did you quit? _____ Alcohol consumption _____

Does any other person in household smoke? No Yes – whom _____

DO YOU HAVE OR HAVE YOU HAD (*check items applicable*):

Cardiovascular:

High blood pressure Chest pain Dizziness

Low blood pressure Heart trouble

EKG: Ever had an electrocardiogram? No Yes – when and where _____

Pulmonary:

Shortness of breath: walking several blocks one flight of stairs on lying down

Does it wake you? No Yes

Chronic cough Pneumonia

Coughing up blood Asthma

Upper Respiratory:

Snoring Change in voice Hayfever/allergies

Do you wake frequently? No Yes Nasal congestion Sinus trouble

Stop breathing while asleep? No Yes Change in smell Sinus headaches

Hoarseness Nosebleeds

DO YOU HAVE OR HAVE YOU HAD (check items applicable):

Renal:

- | | | |
|--|--|---|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Difficult urination | <input type="checkbox"/> Bladder/kidney infection |
| <input type="checkbox"/> Pain with urination | <input type="checkbox"/> Kidney stones | |

Gastrointestinal:

- | | | |
|---|---|--|
| <input type="checkbox"/> Chronic sore throats | <input type="checkbox"/> Sores in mouth | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Chronic stomach pain | <input type="checkbox"/> Colon/bowel disease |
| <input type="checkbox"/> Change in taste | | |

Neurological:

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Weakness/paralysis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Head injury | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Facial pain | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Double vision | <input type="checkbox"/> Insomnia |

Endocrine/Immune System:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pituitary gland problem | <input type="checkbox"/> + HIV/AIDS |
| <input type="checkbox"/> Hyperthyroid (overactive) | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Enlarged glands |
| <input type="checkbox"/> Hypothyroid (underactive) | <input type="checkbox"/> Thyroid gland enlargement | |

Hematology:

- | | | |
|---|---------------------------------|---|
| <input type="checkbox"/> Hemophilia (bleeding disorder) | <input type="checkbox"/> Anemia | <input type="checkbox"/> Bruises or bleeds easily |
|---|---------------------------------|---|

Eyes/Ears:

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain behind the eyes | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Discharge from ears |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Ringing in the ears |
| <input type="checkbox"/> Earaches | | |

Other:

- | | |
|---|--|
| <input type="checkbox"/> Facial/neck/oral lesions | <input type="checkbox"/> Growth neck/face/head |
|---|--|

Past Illness:

- | | | |
|---|---|------------------------------------|
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Syphilis/Gonorrhea | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> German measles | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Cancer (describe): _____ | | |
| <input type="checkbox"/> Other: _____ | | |

FAMILY HISTORY OF THE PATIENT:

	Age	If living (health)	If deceased (age at death/cause)
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers or Sisters	_____	_____	_____
	_____	_____	_____

Has any relative ever had the following (check)

- | | | | | | | | | |
|---------------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing Loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other: _____ | | | | | | | | |

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.