Name: _____ Date of Birth: _____ Today's Date: _____

Home #: _____ Work #: _____ Cell #: _____
(*If patient is a minor)*
Mother's name: _____ Father's name: _____

Medical History: Do you, the patient, have a history of (check all that apply)

___ High blood pressure	___ Lung Disease	___ Thyroid Disease	___ Blood transfusion
___ Diabetes	___ Kidney Disease	___ Tuberculosis	___ Malignant hypothermia
___ Heart Disease	___ Liver disease	___ Psychiatric disease	___ Cancer/Other

Explain all that are checked:_____

List all current medications, including over the counter medications:_____

Drug Allergies: List any drug allergy and it's associated reaction:_____

Surgical History: List previous surgical procedures and date performed:_____

Family History: Does any member of your immediate family have a history of:

___ Cancer	**___ Hearing loss**	**___ Bleeding abnormalities**
___ Heart disease	**___ problems with anesthesia or high fever with anesthesia**	

Explain all that are checked: _____

Social History: Do you ___ smoke ___ drink alcohol ___ drugs

Review of systems: Have you had chronic problems with any of the following:

General:	**___ fever**	**___ chills**	**___ weight loss**	**___ night sweats**
	___ bleeding	**___ bruising**	**___ rashes**	**___ arthritis**
HEENT:	**___ ear infections**	**___ hearing loss**	**___ allergic rhinitis**	**___ nasal congestion**
	___ throat pain	**___ visual problems**	**___ choking**	**___ hoarseness**
CV:	**___ chest pain**	**___ shortness of breath**		
	___ irreg heart beats	**___ circulation problems**		
GI:	**___ nausea**	**___ bloody stool**	**___ swallowing difficulties**	
	___ vomiting	**___ constipation**	**___ heart burn**	
GU:	**___ incontinence**	**___ bladder infections**		
	___ blood in urine	**___ kidney stones**		
Neuro:	**___ seizures**	**___ numbness**	**___ psychiatric illness**	
	___ slurred speech	**___ paralysis**		
Resp:	**___ bronchitis**	**___ pneumonia**	**___ coughing up blood**	
	___ asthma	**___ coughing**		

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