

Name \_\_\_\_\_ Age \_\_\_\_\_ Chart# \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Referred by \_\_\_\_\_  
 New  Updated Data \_\_\_\_\_ Date \_\_\_\_\_  
 Reason For Today's Visit \_\_\_\_\_ Family Physician \_\_\_\_\_

**PREVIOUS SURGERY -**

Have you ever been operated on for any of the following:

	Date		Date
<input type="checkbox"/> Colonoscopy/BE	_____	<input type="checkbox"/> Heart Surgery	_____
<input type="checkbox"/> Appendectomy	_____	<input type="checkbox"/> Breast Surgery	_____
<input type="checkbox"/> Hysterectomy	_____	<input type="checkbox"/> Hernias	_____
<input type="checkbox"/> Gallbladder	_____	<input type="checkbox"/> Hemorrhoidectomy	_____
<input type="checkbox"/> Colon	_____	<input type="checkbox"/> Tonsils	_____
<input type="checkbox"/> Vascular Surgery	_____	<input type="checkbox"/> Laparoscopy	_____
Others: _____			

Remarks: \_\_\_\_\_

If necessary, would you agree to blood or blood products? Yes No (Circle One)

**MEDICAL HISTORY -**

Do you or any family members have a history of any of the following:

	Yourself	Family		Yourself	Family
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer - Other Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Colon Disease	<input type="checkbox"/>	<input type="checkbox"/>	Others _____	<input type="checkbox"/>	<input type="checkbox"/>

**ALLERGIES TO MEDICATIONS** (Please List medicine with symptoms) Allergy to Latex  Yes  No

**MEDICATIONS -** (Please check)  Aspirin  Steroids  Coumadin

Are you taking any other medications?  Yes  No

Medicine Name	Dosage	How many times a day?
_____	_____	_____
_____	_____	_____

Do you smoke?  Yes  No How much? \_\_\_\_\_ How long? \_\_\_\_\_  
 If No, did you previously?  Yes  No How much? \_\_\_\_\_ How long? \_\_\_\_\_  
 Do you drink alcohol?  Yes  No How much? \_\_\_\_\_ How long? \_\_\_\_\_  
 Do you use caffeine?  Yes  No How much? \_\_\_\_\_  
 Do you wear glasses?  Yes  No Contacts?  Yes  No Hearing Aid?  Yes  No Dentures?  Yes  No

**FOR FEMALES -**

Date of last period \_\_\_\_\_ Last Mammogram? \_\_\_\_\_  Menopause  
 How many pregnancies? \_\_\_\_\_ How many children? \_\_\_\_\_ Breastfeed  Yes  No  
 Last pap smear \_\_\_\_\_ Type of Birth Control \_\_\_\_\_