Name: DOB:

Surgical History (Please circle any operations you have had):

Gallbladder ☐	Plastic Surgery ☐	Thyroid ☐
Hernia ☐	Joint Replacement ☐	Heart Surgery ☐
Colon ☐	Back Surgery ☐	Pacemaker ☐
Prostate ☐	Cataracts ☐	Appendectomy ☐

Other operations:

Were there bleeding or anesthetic complications with any of your operations? If yes, please explain:

Past or Present Medical Problems (Circle any that you currently have or have had in the past):

Diabetes ☐	Anemia ☐	Irregular Heart Rate ☐	Fibromyalgia ☐	HIV/AIDS ☐
Stroke ☐	Seizures ☐	Hepatitis (A,B, or C) ☐	High Blood Pressure ☐	Stomach Ulcers ☐
Heart Condition ☐	GERD ☐	Heart Attack ☐	Thyroid Problems ☐	Emphysema/Asthma ☐
Depression ☐	High Cholesterol ☐	Migraines ☐		

Other Medical Conditions:

Do you smoke? Yes ☐ No ☐ **Packs per day:**_____ **How many years?:**_____

Do you drink alcohol? Yes ☐ No ☐ **If yes, how often? Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐**

Please list all medications that you are currently on: _____

_____

_____

Please list all allergies that you have:_____

_____

_____

Name: DOB:

Review of Symptoms

Do you NOW HAVE any problems related to the following body systems? Please circle YES or NO and explain and YES answers in the space provided.

General Symptoms:		**Musculoskeletal:**	
Fever ☐ Yes ☐ No		Joint Pain ☐ Yes ☐ No	
Chills ☐ Yes ☐ No		Neck Pain ☐ Yes ☐ No	
Weight Loss ☐ Yes ☐ No		Back Pain ☐ Yes ☐ No	
Skin Rashes ☐ Yes ☐ No		Arthritis ☐ Yes ☐ No	
Skin Infections ☐ Yes ☐ No			
Neurologic:		**Ear/Nose/Throat:**	
Tremors ☐ Yes ☐ No		Infection ☐ Yes ☐ No	
Dizziness ☐ Yes ☐ No		Sinus Problem ☐ Yes ☐ No	
Numbness ☐ Yes ☐ No		Snoring ☐ Yes ☐ No	
		Blurring Vision ☐ Yes ☐ No	
		Blindness ☐ Yes ☐ No	
Gastrointestinal:		**Respiratory:**	
Abdomen Pain ☐ Yes ☐ No		Wheezing ☐ Yes ☐ No	
Nausea/Vomiting ☐ Yes ☐ No		Persistent cough ☐ Yes ☐ No	
Diarrhea/Constipation ☐ Yes ☐ No		Short of breath ☐ Yes ☐ No	
Heartburn ☐ Yes ☐ No		Winded easily ☐ Yes ☐ No	
Appetite Loss ☐ Yes ☐ No		On Oxygen ☐ Yes ☐ No	
Bloody Stool ☐ Yes ☐ No			
Heart:		**Blood:**	
Chest Pain ☐ Yes ☐ No		Easy Bruising ☐ Yes ☐ No	
Palpitations ☐ Yes ☐ No		Bleeding ☐ Yes ☐ No	
Passing Out ☐ Yes ☐ No		Blood Clots ☐ Yes ☐ No	
Yes No		Swollen Glands ☐ Yes ☐ No	
Psychological:		**Urinary:**	
Are you satisfied with life? ☐ Yes ☐ No		Incontinence ☐ Yes ☐ No	
Are you depressed? ☐ Yes ☐ No		Painful ☐ Yes ☐ No	
Have you ever been suicidal? ☐ Yes ☐ No		Frequency ☐ Yes ☐ No	
		Difficulty ☐ Yes ☐ No	

Physician Use (Comments/Notes):

Physician's Signature:_____ **Date:**_____