Patient name: _____ **Date of Birth:** _____
Height_____ **Weight**_____

Current medical problems:

□ High blood pressure
□ Diabetes
□ Cancer (type :_____)
□ Kidney problems (type :_____)
□ Heart problems (type :_____)
□ Lung problems (type :_____)
□ Liver problem (type :_____)
□ Other: _____

Previous surgeries: (□ none) _____
_____

Current medications please list: (□ none) _____
_____

Do you or blood-related family members have bleeding or clothing problems? _____Yes _____No

Medication allergies: (□ none) □ penicillin □ sulfa □ iodine □ latex □ other: _____

Personal: □ live alone □ live with family (who_____)
tobacco use? □ no □ yes (if yes, how long, how many per day? □ Former Smoker _____
alcohol use? □ no □ yes (□ daily □ weekends socially □ rare holidays, events □ never)
drug use? □ no □ yes (ever have or been treated for a drinking or drug problem? (□ no □ yes)

Family History:
Mother: age: _____ medical problems (if known): _____
(if deceased, age at death: _____ cause: _____
Father: age: _____ medical problems (if known): _____
(if deceased, age at death: _____ cause: _____

Review of systems:
List any recent troubling SYMPTOMS that affect these areas:
□ Fever □ Severe chills □ Soaking night sweats □ Rapid weight gain or loss (lbs: _____)
Eyes/ears/nose/throat: (□ none) _____
Heart/lungs: (□ none) _____
Gastrointestinal: (□ none) _____
Genital/urinary: (□ none) _____
Gynecological: (□ none) _____
Musculoskeletal: (□ none) _____
Neurologic: (□ none) _____
Psychiatric/mood: (□ none) _____
Skin (□ none) _____
Overall sense of health □ Excellent □ Good □ Fair □ Poor

Name of person filling out form: _____
Relationship to patient (□ self) _____
Signature: _____ Date: _____