

LIFESTYLE HABITS	SERIOUS ILLNESSES/INJURIES	DATE	OUTCOME
Which substances do you use and how often? <input type="checkbox"/> Alcohol _____ <input type="checkbox"/> Caffeine _____ <input type="checkbox"/> Drugs _____ <input type="checkbox"/> Tobacco _____ <input type="checkbox"/> Other _____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

OCCUPATION AND JOB DESCRIPTION	SURGERIES AND HOSPITALIZATIONS		
_____	Year	Hospital	Reason for Hospitalization and Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Have any of your blood relatives ever had . . .	_____	_____	_____
Anesthetic complications? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had an anesthetic complication? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Bleeding disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Blood clots? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please give approximate date(s) _____		
Bone disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Rheumatoid arthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No			

FAMILY HISTORY	Age	State of Health	Age at Death	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Sister	_____	_____	_____	_____
Sister	_____	_____	_____	_____
Sister	_____	_____	_____	_____

REVIEW OF SYSTEMS Check any health problems that pertain to you.

General

- Fatigue
- Fever
- Night sweats
- Weakness
- Weight gain/loss

Eyes

- Corrective eyewear
- Eye pain
- Visual disturbance

Ear/Nose/Throat/Mouth

- Earache
- Frequent nose bleed
- Hearing loss
- Sinus pain
- Sore throat
- Tooth/gum problems

Respiratory

- Cough
- Coughing up blood
- Shortness of breath
- Wheezing

Cardiovascular

- Chest pain
- Fainting spells
- Palpitations
- Racing heart rate
- Swollen ankles

Gastrointestinal

- Abdominal pain
- Bloody stools
- Diarrhea
- Heartburn
- Loss of appetite
- Nausea
- Vomiting Bloody

Genitourinary

- Bloody urine
- Incontinence
- Painful urination

Allergy/Immunologic

- Frequent infections
- Runny nose/sneezing
- Skin sensitivities

Neurological

- Balance problems
- Dizziness/lightheadness
- Excessive headaches
- Memory loss or confusion
- Numbness/weakness
- Tremors/seizures

Metabolic/Endocrine

- Excessive thirst/urination
- Glandular or hormone problems
- Heat/cold intolerance

Dermatological

- Open wounds/sores
- Rash

Hematological

- Bruise easily
- Easy/persistent bleeding

Psychiatric

- Agitation
- Depression
- Insomnia
- Suicidal

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or any members of his/her staff responsible for any errors or omissions that may have been made in the completion of this form.

Signature _____ Date _____