PATIENT NAME_____DATE_____
FAMILY DOCTOR_____LAST EXAM_____REFERRING DR._____

I. HISTORY OF PRESENT PROBLEM (TO BE COMPLETED BY NURSE)

II. PAST HISTORY

SURGERY (OPERATIONS) OR ADMISSIONS TO HOSPITAL:

TYPE DATE SURGEON/M.D. COMPLICATIONS

1._____
2._____
3._____
4._____
5._____
6._____

MEDICATIONS (ANY DRUG OR MEDICINE) YOU TAKE NOW:

NAME DOSE HOW OFTEN REASON FOR TAKING MEDICINE

1._____
2._____
3._____
4._____
5._____
6._____

CONSUMPTION OF THE FOLLOWING:

ASPRIN: AMT DAILY_____AMT. WEEKLY_____
ALCOHOL: AMT DAILY_____AMT. WEEKLY_____
VITIMANS: AMT DAILY_____AMT. WEEKLY_____
TOBACCO: AMT DAILY_____AMT. WEEKLY_____
HERBAL SUPPLEMENTS: AMT DAILY_____AMT. WEEKLY_____

ALLERGIES: LIST ANY MEDICATIONS YOU ARE ALLERGIC TO AND EXPLAIN REACTION.
LATEX ALLERGY? _____
1._____3._____
2._____4._____

FAMILY HISTORY: LIST ANY FAMILY HISTORY OF MEDICAL PROBLEMS, OR ILLNESS, INCLUDE HEART AND LUNG PROBLEMS, HIGH BLOOD PRESSURE, DIABETES, ASTHMA, CANCER, STROKE, ECT. IF HISTORY, LIST WHO

HEART PROBLEMS_____BLEEDING PROBLEMS_____
LUNG PROBLEMS_____BLOOD CLOTS_____
HYPERTENSION_____DIABETES_____
MALIGNANT HYPERTHERMIA_____CANCER_____

IV. REVIEW OF SYSTEMS:
ANY MEDICAL PROBLEMS WITH ANY OF THE FOLLOWING: (CIRCLE ANSWER)

NO YES HEAD, IF YES EXPLAIN
NO YES EYES, IF YES EXPLAIN
NO YES EARS, IF YES EXPLAIN
NO YES THYROID, IF YES EXPLAIN
NO YES LUNGS, IF YES EXPLAIN
NO YES HEART, IF YES EXPLAIN
NO YES BLOOD OR BLOOD VESSELS, IF YES EXPLAIN
NO YES DIGESTIVE SYSTEM, IF YES EXPLAIN
NO YES LIVER, IF YES EXPLAIN
NO YES MUSCLE-BONES, IF YES EXPLAIN
NO YES REPRODUCTIVE ORGANS, IF YES EXPLAIN
NO YES KIDNEYS-BLADDER, IF YES EXPLAIN
NO YES OTHER, IF YES EXPLAIN
NO YES PREGNANT NOW? IF YES, DUE DATE_____PHYSICIAN_____
NO YES LOCAL OR GENERAL ANESTHESIA, IF YES EXPLAIN
NO YES BLEEDING PROBLEMS WITH DENTAL WORK, CUTS, SURGERY, EXPLAIN
NO YES BLOOD CLOTS, VARICOSE VEINS, DVT:

(TO BE COMPLETED BY NURSE)
V. EXAM:

HT_____WT_____BP_____P____BRA SIZE_____ DRESS _____PANTS_____BLOUSE____

VI. FINDINGS AND TREATMENT RECOMMENDED: