Name _____DOB _____

SURGICAL HISTORY:

Please check below if you have had any of these surgeries: ❑ **No previous surgery**

❑ Aneurysm - Abdominal
❑ Angioplasty/stents
❑ Appendectomy
❑ Artery bypass of arm or leg
❑ Breast surgery
❑ Caesarean section
❑ Carotid surgery
❑ Cataract surgery
❑ Colon Surgery
❑ Fistula - Which Arm _____
❑ Gall Bladder
❑ Gastric bypass surgery
❑ Heart Stents
❑ Hernia surgery
Where: _____
❑ Hysterectomy
❑ Nasal Surgery
❑ Open Heart surgery
❑ Pacemaker/Defibrillator
❑ Prostate surgery
❑ Spine surgery
❑ Tonsils
❑ Total Hip
❑ Total Knee
❑ Other not listed, explain _____
_____

FAMILY HISTORY:

Please check below if Mother, Father, Siblings have had any of the following: ❑ **No family medical history to report**

	Who		Who		Who
❑ Adverse reaction to anesthesia	_____	❑ Coronary artery disease	_____	❑ Hypertension	_____
❑ Bleeding disorders	_____	❑ Depression	_____	❑ Osteoporosis	_____
❑ Blood clots/Pulmonary embolism	_____	❑ Diabetes	_____	❑ Rheumatoid arthritis	_____
❑ Cancer Type: _____	_____	❑ Heart disease	_____	❑ Stroke	_____

REVIEW OF SYSTEMS:

Please check below if you have any of these medical conditions TODAY or recurring: ❑ **No review of symptoms to report**

Review of systems: check in box=normal Circle positive responses

		OTHER/REMARKS
{ } CONST	fever, chills, fatigue, recent weight gain/loss, appetite problems, night sweats	_____
{ } EYES	double vision, blurring, difficulty seeing, pain	_____
{ } ENT	deafness, sinusitis, hoarseness, dizziness, nose bleeds, ear pain, sore throat	_____
{ } HEART	chest pain, palpitations, murmur, extra beats, arm/jaw pain	_____
{ } LUNG	shortness of breath, wheezing, cough, bloody sputum, asthma	_____
{ } INTESTINAL	constipation, diarrhea, rectal bleeding, nausea, vomiting, heartburn, abdominal pain	_____
{ } URINARY	pain with urination, frequency, blood in urine, hesitancy, incontinence, stones	_____
{ } BREAST	breast masses, pain, discharge, cancer	_____
{ } GYN	Irregular periods, hysterectomy, partial/complete	_____
{ } NEURO	seizures, loss of balance/coordination, weakness, memory loss, slurred speech	_____
{ } ENDOCRINE	excessive thirst, excessive urination, heat/cold tolerance	_____
{ } SKIN	persistent rashes or lesions, changes in moles, bleeding, itching	_____
{ } MUSCULOSKELETAL	stiffness, joint pain/deformity, muscle wasting, spine pain radiating to arms/legs	_____
{ } BLOOD/LYMPHATIC	anemia, bleeding tendencies, swollen lymph nodes	_____
{ } PSYCH	depression, anxiety, hallucinations, sleep disturbances	_____
{ } ALLERGIC AND IMMUNOLOGIC	hives, eczema, persistent itching	_____

Other problems not covered above:

To Be Filed Out By Nurse

HEIGHT: _____ WEIGHT: _____ TEMP: _____ PULSE: _____ O2 SAT: _____

BP RIGHT ARM: _____ BP LEFT ARM: _____

FLU SHOT: ❑ Yes ❑ No Month _____ PNEUMONIA VACCINE: ❑ Yes ❑ No