

### General Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
 Cardiologist: \_\_\_\_\_ Any other physicians you are seeing : \_\_\_\_\_  
 Preferred Pharmacy: \_\_\_\_\_

I am a new patient       I am a returning patient. Last visit: \_\_\_\_\_

What are we seeing you for today? \_\_\_\_\_  
 How long have your symptoms been present? (if applicable) \_\_\_\_\_

### Medical History

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Abnormal heart rhythm                  | <input type="checkbox"/> Enlarged prostate (BPH)              | <input type="checkbox"/> Kidney disease               |
| <input type="checkbox"/> Anemia                                 | <input type="checkbox"/> Epilepsy                             | <input type="checkbox"/> Kidney stones                |
| <input type="checkbox"/> Aneurysm                               | <input type="checkbox"/> Fibromyalgia                         | <input type="checkbox"/> Liver disease                |
| <input type="checkbox"/> Anxiety                                | <input type="checkbox"/> Gallbladder disease                  | <input type="checkbox"/> Macular degeneration         |
| <input type="checkbox"/> Arthritis                              | <input type="checkbox"/> Gastritis/duodenitis (please circle) | <input type="checkbox"/> Mental illness               |
| <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> GERD (acid reflux)                   | <input type="checkbox"/> Migraine/headaches           |
| <input type="checkbox"/> Barrett's esophagus                    | <input type="checkbox"/> Glaucoma                             | <input type="checkbox"/> Multiple Sclerosis           |
| <input type="checkbox"/> Bipolar disorder                       | <input type="checkbox"/> Gout                                 | <input type="checkbox"/> Open wounds                  |
| <input type="checkbox"/> Bleeding/clotting disorder             | <input type="checkbox"/> H. Pylori                            | <input type="checkbox"/> Osteoarthritis               |
| <input type="checkbox"/> Cancer (type) _____                    | <input type="checkbox"/> Hearing loss                         | <input type="checkbox"/> Osteoporosis                 |
| <input type="checkbox"/> Carotid artery disease                 | <input type="checkbox"/> Heart attack (MI)                    | <input type="checkbox"/> Peripheral vascular disease  |
| <input type="checkbox"/> Cataracts                              | <input type="checkbox"/> Heart disease (CAD)                  | <input type="checkbox"/> Peptic ulcer disease         |
| <input type="checkbox"/> Chest pain                             | <input type="checkbox"/> Heart valve problems                 | <input type="checkbox"/> Pneumonia                    |
| <input type="checkbox"/> Congestive heart failure               | <input type="checkbox"/> Hepatitis                            | <input type="checkbox"/> Rheumatoid arthritis         |
| <input type="checkbox"/> COPD                                   | <input type="checkbox"/> High cholesterol                     | <input type="checkbox"/> Seizures                     |
| <input type="checkbox"/> Crohn's disease/ Ulcerative colitis    | <input type="checkbox"/> High blood pressure                  | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Degenerative disk disease              | <input type="checkbox"/> HIV                                  | <input type="checkbox"/> Sleep apnea                  |
| <input type="checkbox"/> Dementia                               | <input type="checkbox"/> Hyperthyroidism                      | <input type="checkbox"/> Stomach ulcers               |
| <input type="checkbox"/> Depression                             | <input type="checkbox"/> Hypertension                         | <input type="checkbox"/> Stroke/TIA                   |
| <input type="checkbox"/> Diabetes Mellitus                      | <input type="checkbox"/> Hypothyroidism                       | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Diverticulosis/diverticulitis (circle) | <input type="checkbox"/> Inflammatory bowel disease           | <input type="checkbox"/> Other _____                  |
| <input type="checkbox"/> Emphysema                              | <input type="checkbox"/> Intestinal problems                  |   |

### Surgical History

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> AAA repair                      | <input type="checkbox"/> Defibrillator                     | <input type="checkbox"/> Pap smear (date) _____       |
| <input type="checkbox"/> Arthroscopy                     | <input type="checkbox"/> Eye surgery                       | <input type="checkbox"/> Prostate surgery             |
| <input type="checkbox"/> Appendectomy                    | <input type="checkbox"/> Gallbladder                       | <input type="checkbox"/> Sinus surgery                |
| <input type="checkbox"/> Back surgery                    | <input type="checkbox"/> Heart cath (date) _____           | <input type="checkbox"/> Skin cancer excision         |
| <input type="checkbox"/> Bariatric surgery (weight loss) | <input type="checkbox"/> Hernia repair                     | <input type="checkbox"/> Spine surgery                |
| <input type="checkbox"/> Breast                          | <input type="checkbox"/> _____ (type & date) _____         | <input type="checkbox"/> Thyroid surgery              |
| <input type="checkbox"/> Cardiac surgery                 | <input type="checkbox"/> Hip replacement (left or right?)  | <input type="checkbox"/> Tonsillectomy                |
| <input type="checkbox"/> _____ (bypass/stent/valve)      | <input type="checkbox"/> Hysterectomy                      | <input type="checkbox"/> Upper endoscopy (date) _____ |
| <input type="checkbox"/> Carotid endarterectomy          | <input type="checkbox"/> Knee replacement (left or right?) | <input type="checkbox"/> Vasectomy                    |
| <input type="checkbox"/> Carpal tunnel release           | <input type="checkbox"/> Mammogram (date) _____            | <input type="checkbox"/> Other surgeries: _____       |
| <input type="checkbox"/> Cesarean section                | <input type="checkbox"/> Neck surgery                      | _____   |
| <input type="checkbox"/> Colon/intestinal                | <input type="checkbox"/> Orthopaedic surgery               | _____   |
| <input type="checkbox"/> Colonoscopy (date) _____        | <input type="checkbox"/> Pace maker                        | _____   |

### Social History

Tobacco Use:     Never     Current/Former Smoker (quit date \_\_\_\_ )     Chewing Tobacco     E-cigs     Other \_\_\_\_\_  
 Alcohol:         Never         Occasional                       Daily (#drinks/day)     History of alcohol abuse  
 Drug Use:         Never         History of drug abuse (type) \_\_\_\_\_     Current drug use (type) \_\_\_\_\_  
 Caffeine Use:     Never         Occasional        Daily (#drinks/day) \_\_\_\_\_

## Medications (name and dosage)


## Immunization

Influenza - Date \_\_\_\_\_ Pneumococcal (Prevnar 13 or Pneumovax) - Date \_\_\_\_\_  
 Tetanus & Diphtheria - Date \_\_\_\_\_ Zoster - Date \_\_\_\_\_

## Allergies

Please list with reaction: \_\_\_\_\_  
 \_\_\_\_\_

Any previous issues with anesthesia:  No  Yes (please explain): \_\_\_\_\_

## Family History

<sup>3</sup>/<sub>4</sub> I do not know my family history  
<sup>3</sup>/<sub>4</sub> Family history of issues with anesthesia

Mother Alive    Deceased	<sup>3</sup> / <sub>4</sub> Diabetes <sup>3</sup> / <sub>4</sub> Other _____	High Blood Pressure	Heart Disease	Cancer (type) _____
Father Alive    Deceased	<sup>3</sup> / <sub>4</sub> Diabetes <sup>3</sup> / <sub>4</sub> Other _____	High Blood Pressure	Heart Disease	Cancer (type) _____
Sister(s) # _____ ___Alive    ___Deceased	<sup>3</sup> / <sub>4</sub> Diabetes <sup>3</sup> / <sub>4</sub> Other _____	High Blood Pressure	Heart Disease	Cancer (type) _____
Brother(s) # _____ ___Alive    ___Deceased	<sup>3</sup> / <sub>4</sub> Diabetes <sup>3</sup> / <sub>4</sub> Other _____	High Blood Pressure	Heart Disease	Cancer (type) _____

**\*\*STOP\*\***

## Review of Systems (below to be completed by provider)

### General History:

- Weight gain
- Weight loss
- Fatigue

### Ear/Nose/Throat:

- Hoarseness
- Choking
- Sinus drainage
- Sore throat

### Neurologic:

- Muscle weakness
- Numbness
- Seizures
- Memory loss

### Respiratory:

- Difficulty breathing
- Wheezing
- Cough
- Recent infection

### Cardiac:

- Chest pain
- Palpitations
- Swollen feet
- Last stress test \_\_\_\_\_

### Gastrointestinal

- Heartburn
- Difficulty swallowing
- Abdominal pain
- Nausea
- Vomiting
- Bloating
- Rectal bleeding/dark stool
- Constipation
- Diarrhea
- Change in size of stools
- Pain or bulge at a scar
- Pain or bulge in the groin
- Upper or right sided abdominal pain

### Breast (Female):

- Breast mass
- Nipple discharge
- Breast pain
- Date of mammogram \_\_\_\_\_

### OB/GYN (Female):

- Date of last period: \_\_\_\_\_
- Age of menstruation: \_\_\_\_\_
- Age of menopause: \_\_\_\_\_

### Genitourinary:

- Difficulty urinating
- Urinating frequently
- Blood in urine
- Incontinence

### Endocrine:

- Hormone problem
- Excessive thirst/urination
- Heat or cold intolerance
- Neck mass

### Hematologic:

- Slow wound healing
- Easy bruising or bleeding
- Anemia
- Enlarged glands
- Varicose veins

### Dermatologic:

- Recent change in moles
- Rashes
- Masses below the skin
- Lesions that bleed
- Lesions that don't heal
- Skin tags
- Itchy skin lesion