

Name: _____

Chief Complaint: Why are you seeing the doctor today? _____

ALLERGIES: _____

MEDICATIONS: _____

REVIEW OF SYSTEMS: Are you currently having or have you had problems with: (circle answers)

Eyes	No	Yes	Bleeding Problems	No	Yes	Epilepsy	No	Yes
Ears, Nose, Throat	No	Yes	Balance Problems	No	Yes	Ulcers	No	Yes
Thyroid	No	Yes	Numbness/Tingling	No	Yes	TB	No	Yes
Heart	No	Yes	Swelling of Ankles	No	Yes	Digestion	No	Yes
Lungs, Breathing	No	Yes	Blackouts/Fainting	No	Yes	Cancer	No	Yes
Psychological Problems	No	Yes	Arthritis	No	Yes	Diabetes	No	Yes
Bowel Movement	No	Yes	AIDS	No	Yes	Polio	No	Yes
Bladder Problems	No	Yes	High Cholesterol	No	Yes	Last EKG	_____	
High Blood Pressure	No	Yes	Last Chest X-ray	_____		Last blood work	_____	
Height	_____		Weight	_____				

Describe ALL YES Responses: _____

Surgeries / Hospitalizations: Name of hospital / lab / doctor's office: _____

Date	Reason for Hospitalization	Complications

Have you ever had general anesthesia? (NO) (YES) Problems – describe _____

Family History of cancer, heart disease, diabetes, etc. _____

Exercise: never rarely monthly weekly daily what type _____

Special diet Y N **History of substance abuse** Y N **Smoke** Y N **Previously smoked** Y N

Drink alcohol Y N daily 1-2 x/ week 1-2x/ month **Do you live alone** Y N

Patient Medical History:

Surgeries / Hospitalizations:

Date	Reason for Hospitalization	Complications

Have you ever had general anesthesia? (NO) (YES)

Have you had problems with anesthesia? (NO) (YES) Describe: _____

Reviewed by: _____

Date: _____