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Patient Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: _____ Cell Phone: _____

DOB: ___/___/_____ Age: _____ Sex: M F How did you find us? _____

Referring Doctor: _____ Primary Care Provider: _____

Reason for today's visit: _____

Medical History

Current Medical Problems: _____

_____

_____

Please list any previous surgeries and/or hospitalizations:

Type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____

Current Medication/Dose and Frequency (including herbs, vitamins, and over the counter medicine): _____

_____

_____

Have you had any problems with anesthesia? Y N

If so, explain: _____

Blood thinners (Aspirin, Plavix, Coumadin, Ibuprofen): _____

Infections (i.e. MRSA, C. Diff, etc.) _____

History of blood clots: _____

Allergies to Medications: None: _____ See Attached: _____ Allergy to Latex? Y N

Do you form keloids or scars? Y N

Have you ever taken cortisone or steroids? Y N What, when, how, why and how long? _____

_____

Social History

Marital Status (please circle): Single Married Divorced Widowed

Occupation: _____

Are you disabled? Y N If so, why? _____

Do you smoke? Y N How long? _____ Quantity: _____ Quit? _____

Do you drink? Y N How long? _____ Quantity: _____ Quit? _____

Do you use street drugs? Y N How long? _____ Quantity: _____ Quit? _____

Family History

☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Bleeding/Clotting Disorder

If any of the above apply, please explain medical condition and relation to patient below: _____

_____

_____

Females Only

Are you currently pregnant? Y N Number of pregnancies: _____ Age of first pregnancy: _____

Breast feeding? Y N How many children: _____

History of miscarriages: Y N

Are you presently using contraceptives? Y N Type: _____

Last mammogram: _____/_____/_____ Result: _____ ☐ Never had one

Previous breast disease, surgeries or biopsies: _____

Have you experienced any nipple discharge? Y N Color: _____

Family history of breast cancer: Y N Explain: _____

Review of Systems

Have you ever had any of the following? (Check all that apply)

General:
____ Weight loss or gain
____ Lymph node problems
____ Excessive Fatigue
____ Fever

Endocrinology:
____ Thyroid problems
____ Adrenal problems
____ Diabetes

Ear, Nose, Throat, Mouth:
____ Hearing aide/loss
____ Snoring
____ Sore Throat
____ Hoarseness

Cardiovascular:
____ Chest pain/heart attack
____ Heart Murmur
____ High Blood Pressure
____ Mitral Valve Prolapse
____ Ankle Swelling
____ Phlebitis/DVT

Integumentary:
____ Skin Cancer
____ Lesions

Musculoskeletal:
____ Arthritis
____ Fractures

Urinary:
____ Bladder problems
____ Kidney problems

Respiratory:
____ Chronic cough
____ Shortness of breath
____ Asthma
____ COPD/Emphysema
____ Sleep Apnea
____ Tuberculosis

Eyes:
____ Glasses
____ Contacts
____ Glaucoma

Hematologic/immune:
____ Lymphoma
____ Leukemia
____ Bleeding disorders
____ Positive for AIDS/HIV
____ Lupus
____ Immunological disorders
____ Allergies

Neuro/Psych:
____ Numbness/tingling
____ Stroke
____ Severe Headaches
____ Mental Health
____ Anxiety/Depression
____ Seizures

Gastrointestinal
____ Difficulty swallowing
____ Ulcers
____ Reflux/Heartburn
____ Liver disease/Hepatitis
____ Abdominal Pain
____ Blood in stool
____ Bowel change