



NAME: \_\_\_\_\_

DRUG ALLERGIES or ADVERSE REACTIONS:  NO  YES – Please list: \_\_\_\_\_

IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING, PLEASE CIRCLE:

*SHELLFISH IODINE X-RAY DYE EGGS POULTRY FEATHERS LATEX METAL NICKEL*

If allergic, what was your reaction? \_\_\_\_\_

LIST ALL MEDICATIONS AND SUPPLEMENTS. Please Include Dosage:  No Medications

Do you take any blood thinners?  NO  YES

PRESCRIPTION MEDICATIONS: \_\_\_\_\_

OVER THE COUNTER MEDICATIONS: \_\_\_\_\_

VITAMINS OR SUPPLEMENTS: \_\_\_\_\_

**YOUR MEDICAL HISTORY Continued – Please mark every area**

	Year	Hospital
<b>HOSPITALIZATIONS:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes—please explain		
_____	_____	_____
_____	_____	_____
_____	_____	_____
<b>SURGERY (TYPE):</b> <input type="checkbox"/> No <input type="checkbox"/> Yes—please explain		
_____	_____	_____
_____	_____	_____

NAME: \_\_\_\_\_

**FAMILY HISTORY – Please mark every area**

Do you have a <u>FAMILY</u> history of:	YES	No	Comments
Cancer (Location _____)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Clots/Blood Diseases (Factor V), etc	<input type="checkbox"/>	<input type="checkbox"/>	_____

**SOCIAL HISTORY – Please mark every area**

YOUR PERSONAL HABITS: Do you...	YES	No	If YES, Please explain:
Smoke? / Use any tobacco products? If ever, when did you stop?	<input type="checkbox"/>	<input type="checkbox"/>	how much? _____ _____
Use alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	how much? _____
Were you ever a heavy drinker?	<input type="checkbox"/>	<input type="checkbox"/>	
Use illegal drugs?	<input type="checkbox"/>	<input type="checkbox"/>	

**REVIEW OF SYSTEMS – Please mark every area**

Have you recently been troubled with any of the following symptoms?

	YES	NO		YES	NO
Double / Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Vomited Blood	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Decreased Urine	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Pus in Urine	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Pain while Urinating	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of Feet	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Black or Tarry Stools	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Stools	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Change in BMS	<input type="checkbox"/>	<input type="checkbox"/>	Depression/Worry	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>			

The above information is true and correct to the best of my belief.

\_\_\_\_\_  
Patient Signature (Parent or Guardian for Minor) / Date

\_\_\_\_\_  
Physician Signature / Date

**CLINICAL ASSISTANT/REVIEWER INITIALS:** \_\_\_\_\_

Revised 02/10