PATIENT MEDICAL/HISTORY INFORMATION

Primary (Family) Doctor_____ Referring Doctor_____
First Last First Last

Reason for visit: _____

Drug Allergies: _____

Current Medications: _____

CHECK APPROPRIATE BOX AND UNDERLINE THOSE THAT APPLY:

❑ Yes ❑ No Do you smoke ? If yes, number of cigarettes per day _____
❑ Yes ❑ No Do you take aspirin on a regular basis? Ibuprofen or coumadin?
❑ Yes ❑ No Do you have a pacemaker?
❑ Yes ❑ No Are you diabetic? If yes, are you insulin dependent? ❑ Yes ❑ No Oral med? ❑ Yes ❑ No
❑ Yes ❑ No History of Drug/Alcohol Abuse? Received Treatment? ❑ Yes ❑ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

❑ Yes ❑ No Abnormal chest X-Ray?
❑ Yes ❑ No Anesthesia complications?
❑ Yes ❑ No Abnormal bleeding, anemia?
❑ Yes ❑ No High blood pressure?
❑ Yes ❑ No Stroke?
❑ Yes ❑ No Tuberculosis?
❑ Yes ❑ No Are you HIV positive or do you have AIDS?
❑ Yes ❑ No Do you have Hepatitis?
❑ Yes ❑ No Any other Illness? Explain _____
❑ Yes ❑ No Cancer? Type _____ Year of onset____ Radiation? ❑ Yes ❑ No Chemotherapy? ❑ Yes ❑ No
List any surgery: _____

FAMILY HISTORY

❑ Yes ❑ No Any immediate family history of Cancer? If yes, Type _____ Relationship_____

REVIEW OF SYMPTOMS

CHECK APPROPRIATE BOX AND UNDERLINE THOSE THAT APPLY:

❑ Yes ❑ No Skin rash, unhealed sores, excessive bruising or changing mole?
❑ Yes ❑ No Significant headaches, seizures, slurred speech?
❑ Yes ❑ No Blurred vision, double vision, cataracts or glaucoma?
❑ Yes ❑ No Cough, shortness of breath, wheezing or asthma?
❑ Yes ❑ No Chest pain or pressure, irregular or rapid heartbeats?
❑ Yes ❑ No Have you ever been diagnosed with mitral valve prolapse?
If yes, do you need antibiotic prior to a procedure? ❑ Yes ❑ No
❑ Yes ❑ No Pain in your calves or legs when you walk?
❑ Yes ❑ No Enlarged lymph nodes or glands?

FOR FEMALE PATIENTS ONLY:

❑ Yes ❑ No Abnormal nipple discharge or breast lump?
❑ Yes ❑ No Have you had menopause or a hysterectomy?
❑ Yes ❑ No Might you be pregnant at this time?
Date of last mammogram: _____

Patient/Guardian Signature_____ Date _____

Reviewing Physician_____ RN_____ Date _____