

**Please complete to the best of your knowledge:**

**Main complaint or reason for consultation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Height:\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_Could you be pregnant? YES NO N/A

**Current Medical Problems:**

DiabetesHigh Blood Pressure Heart disease Stroke Asthma Cancer Bleeding Disorder

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Past Surgical History (Please list all past surgeries minor/major and dates):**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List of Current Medications:**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Allergies (list medication and reaction):** **No Known Medication Allergies**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Are you allergic to Latex?** **Yes** **No Are you allergic to Iodine?** **Yes** **No**

**Social History:**

Marital Status: Single Married Divorced Widowed

Occupation: How long?

Work Status: Fulltime Part-time Seasonal Unemployed: how long: \_\_\_\_ Retired Disabled

Are you currently involved in a: Disability claim Workers compensation Lawsuit

Do you smoke? No Quit (year) Yes: Packs per day, Years

**Family History: (NOTE: provide which family member)**

**Diabetes:** Mother Father Grandparent: Paternal Maternal Sibling

**High Blood pressure:** Mother Father Grandparent: Paternal Maternal Sibling

**Heart Disease:** Mother Father Grandparent: Paternal Maternal Sibling

**Stroke:** Mother Father Grandparent: Paternal Maternal Sibling

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**Family History – Continued:**

**Bleeding disorder:** Mother Father Grandparent: Paternal Maternal Sibling

**Cancer:** Mother Father Grandparent:Paternal Maternal Sibling

**Review of Systems (check yes or no):**

 **Y N Y N Y N**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Constitutional** | Weight loss/gain |  |  | Fatigue |  |  | Fevers |  |  |
| **Eyes** | Change in vision |  |  | Eye disease/injury |  |  | Dry eyes |  |  |
| **ENT** | Do you wear hearing aids? |  |  | Bloody Nose |  |  | Mouth Sores |  |  |
| **Cardiovascular** | Chest pain |  |  | Swelling leg/feet |  |  | Shortness of breath |  |  |
| **GI** | Abdominal pain |  |  | Rectal bleeding |  |  | Frequent diarrhea |  |  |
| **Urinary** | Frequent urination |  |  | Blood in urine |  |  | Incontinence |  |  |
| **Musculoskeletal** | Joint Pain/swelling |  |  | Muscle Pain |  |  | Difficulty walking |  |  |
| **Skin** | Rashes/Itching |  |  | Change in moles/skin color |  |  | Change in hair/nails |  |  |
| **Neurological** | Headaches |  |  | Light headedness/dizziness |  |  | Numbness/tingling |  |  |
| **Psychiatric** | Memory loss or confusion |  |  | Anxiety |  |  | Depression |  |  |
| **Endocrine** | Hormone problem |  |  | Excessive skin dryness |  |  | Heat or cold intolerance |  |  |
| **Hematologic**  | Bruising |  |  | Slow to heal cuts/wounds |  |  | Easy bleeding |  |  |

**Thank you for completing this form. Please bring it with you to your appointment.**