Patient Name_____ Date of Birth_____ Today's Date_____

Referring Physician _____

Primary Care Physician **GYN/OB Physician**

Reason for your visit today? Be precise

MEDICATIONS

Please list all current medications including over -the-counter drugs:_____

ALLERGIES

Do you have any allergies/reactions to

PAST MEDICAL HISTORY

Do you have or have you had any of the following conditions?	Type/Year Diagnosed
Cancer (kidney,bladder)	
Heart (chestpain, heart attach, murmur)	
High Blood Pressure	
Pacemaker	
Blood or clotting problems	
Breast- cancer	
Stomach/Liver (refulx, bleeding, hepatits, etc)	
Bowels (change in bowel hapits, contipation, diarrhea)	
Glands (Diabetes, thyroid, gout)	
Gynecologic System (female /male organs)	
Musculoskeletal (arthritis, disc disease)	
Eyes/Ears/Nose/Throat	
Stroke	
Lung (asthma,	
Bladder Disease	
Brain/Nervous System (seizure, blackout spells)	
Skin (rash, psoriasis, hives)	
Any other illnesses?	
Have you had any accidents/injuries within the last 24	

Please list any other medical conditions (including the date of onset)

Patient Name_____ Date of Birth_____ Today's Date_____

PAST SURGICAL HISTORY

Type of Operation	Surgeon/Location	Date(s)
Are you a Bloodless Medicine patient	If yes, give which hospital	
Do you have an artifical joints and/or heart valves	If yes, give which & date:	
Have you ever had a blood transfusion	If yes, when?	

FAMILY HISTORY

Relation	**AGE**	**STATE OF HEALTH**	**IF DECEASED, CAUSE/AGE AT DEATH**
Mother			
Father			
Siblings			
Spouse			
Children			

Please list any diseases that run in your family, such as cancer, kidney stones, diabetes, etc

Disease	Family member

Height: Weight:	**Martial Status:** Single Married Divorced Domestic Partner Number of Children (if any)_____

Occupation:	**Smoking/Smokless Tobacco** ☐ **YES** ☐ **NO** How much do/did you smoke/use?
Alcohol ☐ **Yes** ☐ **No** How much ?	**Former** When did you quit?

Patient Name_____ Date of Birth_____ Today's Date_____

REVIEW OF SYSTEMS

Have you experienced any of these problems during the past month?

	YES	NO		YES	NO
Weight loss	☐	☐	Chest pain/palpitations	☐	☐
Fevers	☐	☐	Mood changes or Depression	☐	☐
Chillls	☐	☐	Trouble sleeping	☐	☐
Skin rash or itching	☐	☐	Frequent indigestion	☐	☐
Headaches	☐	☐	Nausea or vomiting	☐	☐
Loss of balance or coordination	☐	☐	Diarrhea or constipation	☐	☐
Hearing loss	☐	☐	Jaundice	☐	☐
Vision trouble	☐	☐	Rectal bleeding	☐	☐
Do you wear contacts or glasses	☐	☐	Foul smelling urine	☐	☐
Arm or leg weakness	☐	☐	Blood in urine	☐	☐
Sinus drainage	☐	☐			
Difficutly swallowing	☐	☐			
Hoarseness or change in voice	☐	☐			
Sores in mouth or lip	☐	☐			
Cough	☐	☐			
Coughed up or spit up blood	☐	☐			

UROLOGY

Check approprite box:	**YES**	**NO**
Painful Urination	☐	☐
Increased frequency of urinaton	☐	☐
Blood in urine	☐	☐
Inability to urinate	☐	☐
Urinating at night	☐	☐
Weak or hesitant urinary stream	☐	☐
UTI with fever	☐	☐
Pain in the lower abdomen	☐	☐
Male infertility	☐	☐
Prostate problems	☐	☐
Testicle Pain	☐	☐
Sexual Dysfunction	☐	☐
Have you ever had a sexually transmitted disease? Circle: Gonorrhea Chlamydia Herpes Genital Warts PID Other_____	☐	☐
Kidney stones	☐	☐
Kidney cancer	☐	☐

_____ _____

Patient Signature Date