

## CHIEF COMPLAINT

Why are you seeing the doctor today?

Height \_\_\_\_\_ Weight \_\_\_\_\_ Dominant Hand:  Right  Left

## HISTORY OF PRESENT ILLNESS

When did this problem begin? \_\_\_\_\_

Is this problem you are seeing the doctor for today a result of:  Work  Car  Accident  Other

## PAST MEDICAL HISTORY

Surgeries/Hospitalizations	Year	Complications
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had general anesthesia?  Yes  No

Have you ever had problems with anesthesia?  Yes  No

## FAMILY HISTORY

Check any of the following diseases occurring in your immediate family:

Heart Disease  Diabetes  Epilepsy  High Blood Pressure  COPD  Stroke  
 Lupus  Cancer  RA

## SOCIAL HISTORY

Employed?  Yes  No Occupation \_\_\_\_\_

Student?  Yes  No Retired?  Yes  No

If retired or medically disabled, what was your occupation? \_\_\_\_\_

If surgery is likely, do you have someone who could assist you with baking, cooking, general care, etc?  
 Yes  No

Do you exercise?  Yes  No If so, how often  Daily  Weekly  Monthly

Do you use or take any of the following:

Tobacco  Yes  No Amount per day \_\_\_\_\_ How long have you smoked? \_\_\_\_\_

Alcohol  Yes  No Amount per day \_\_\_\_\_

Street Drugs  Yes  No

If yes, what type and amount: \_\_\_\_\_

What is your religion? \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Update \_\_\_\_\_ Update \_\_\_\_\_ Update \_\_\_\_\_ Update \_\_\_\_\_ Update \_\_\_\_\_ Update \_\_\_\_\_ Update \_\_\_\_\_

Name: \_\_\_\_\_ Today's Date \_\_\_\_\_