

Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Male  Female Height \_\_\_\_\_ Weight \_\_\_\_\_

Reason for Visit \_\_\_\_\_

<b>Office Use Only</b>
Temp _____

**Prior surgeries and hospitalizations:**

**Current medications:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Surgical Issues** (check all that apply)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Anesthesia problems (you or a close relative) | <input type="checkbox"/> Pregnant / possibly pregnant   | <input type="checkbox"/> Contact lenses      |
| <input type="checkbox"/> Bleeding disorder or on a blood thinner       | <input type="checkbox"/> Objection to blood transfusion | <input type="checkbox"/> Reflux or heartburn |
| <input type="checkbox"/> Loose / removable dental work                 | <input type="checkbox"/> Nausea following anesthesia    | <input type="checkbox"/> Sleep apnea         |

Comments: \_\_\_\_\_

**Allergies** (medications or other): If possible please indicate the reaction (e.g. hives, rash, difficulty breathing)

\_\_\_\_\_

\_\_\_\_\_

**Head and Neck**

- |  |                     |                |
|--|---------------------|----------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw pain (TMJ pain) | Comments _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Neck Stiffness      | _____          |

**Respiratory**

- |  |                     |       |
|--|---------------------|-------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Smoker              | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of breath | _____ |

**Cardiovascular**

- |  |   |       |
|--|---|-------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure                                     | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke  | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Coronary artery disease<br>(angina, prior heart attack) | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Congestive heart failure                                | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular rhythm  | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart murmur  | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Peripheral vascular diseases                            | _____ |

**Gastrointestinal/Renal**

- |  |                |       |
|--|----------------|-------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers         | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver problems | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney failure | _____ |

**Musculoskeletal**

- |  |                         |       |
|--|-------------------------|-------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis               | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis/osteopenia | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Joints       | _____ |

**Neurologic**

- |  |           |       |
|--|-----------|-------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures  | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Paralysis | _____ |

**Metabolic**

- |  |                 |       |
|--|-----------------|-------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes        | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid problem | _____ |

**Infectious Disease**

- |  |                        |       |
|--|------------------------|-------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV                    | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis (B,C)        | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | MRSA (past or present) | _____ |

**Social**

- |  |                               |       |
|--|-------------------------------|-------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Alcohol or recreational drugs | _____ |
|--|-------------------------------|-------|

<b>Office Use Only</b>
Reviewed by patient
<input type="checkbox"/> No changes from prior
<input type="checkbox"/> Changes noted
Date ____/____/____
Reviewed by patient
<input type="checkbox"/> No changes from prior
<input type="checkbox"/> Changes noted
Date ____/____/____
Reviewed by patient
<input type="checkbox"/> No changes from prior
<input type="checkbox"/> Changes noted
Date ____/____/____
Reviewed by MD
Sig _____
Date ____/____/____
Reviewed by MD
Sig _____
Date ____/____/____
Reviewed by MD
Sig _____
Date ____/____/____

