

DEMOGRAPHICS	Today's Date: ___/___/___ Patient's Name: _____				
	Date of Birth: ___/___/___		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
	SS#: _____		Race: <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Aleut <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Latin <input type="checkbox"/> Other		
	Referring Doctor: _____				
	Other Doctors: _____				
Reason for your visit: _____					
PMH	Illnesses / Diseases – check all that apply to you				
	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart Disease <input type="checkbox"/> Unusual Bleeding <input type="checkbox"/> Blood Disorders <input type="checkbox"/> Blood Clots <input type="checkbox"/> Stroke <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Cancer (describe below) <input type="checkbox"/> Other (describe below)				
SURGICAL/TREATMENT HISTORY	Previous surgery	Date of surgery	Surgeon's name		
	Please list any injuries: _____				
Have you had ...					
Prior Radiation? <input type="checkbox"/> No <input type="checkbox"/> Yes Area: _____ # of Treatments: _____ Year: _____					
Prior Chemotherapy? <input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____ Year: _____					
FAMILY HISTORY	Check all that apply	Father	Mother	Brother	Sister
	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Unusual Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cancer (describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SOCIAL HISTORY	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Primary Caregiver: _____				
	Children: <input type="checkbox"/> No <input type="checkbox"/> Yes - # of children: _____ Education: Highest grade/degree completed: _____				
	Occupation: _____ Retired? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>If retired list previous occupation</small>				
	Any exposure to hazardous materials? <input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____				

SOCIAL HISTORY (cont)

Alcohol use at present? No Yes If yes, how much? _____ How often: _____
 In the past? No Yes If yes, when did you quit? _____ (date)
 Tobacco use at present? No Yes Type: Cigarettes Cigars Oral Tobacco Daily amount: _____ # of years _____
 In the past? No Yes If yes, when did you quit? _____ (date)
 Any illicit / recreational / street drug use / abuse? No Yes
 If yes, please describe: _____

ALLERGIES

Drug or situation	(Please list the type of adverse reaction)

MEDICATIONS

Drug name	Dosage	How often

REVIEW OF SYSTEMS

Check all that apply:

<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Headaches
<input type="checkbox"/> Fever	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Fainting
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Generalized weakness	<input type="checkbox"/> Cough: <input type="checkbox"/> Wet <input type="checkbox"/> Dry	<input type="checkbox"/> Localized weakness / numbness
<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Pain (where/describe) _____
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Leg swelling	Last CXR (date) _____
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Heart too fast / slow	<input type="checkbox"/> Other bleeding (where/describe) _____
<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Nausea	_____
<input type="checkbox"/> Throat Pain	<input type="checkbox"/> Vomiting	
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Trouble swallowing	<input type="checkbox"/> Constipation	
	<input type="checkbox"/> Passing blood	
<input type="checkbox"/> Pain in bones	Last Rectal Exam (date) _____	
<input type="checkbox"/> Pain in joints	Last Colonoscopy/Flex Sig (date) _____	
<input type="checkbox"/> Depression	<input type="checkbox"/> Skin rashes/change in a mole (where/describe): _____	
<input type="checkbox"/> Anxiety	_____	

FEMALES ONLY

Menstrual Cycle: Regular Irregular Heavy Light Passing clots
 Spotting between cycles Cramps
 Date last menstrual cycle: ___/___/___ Menopause? No Yes If yes, date: ___/___/___
 Date last pap smear: ___/___/___ Date last breast exam: ___/___/___ Bra size: _____ (Breast cancer patients only)
 Date last mammogram: ___/___/___ Location: _____