Please complete and return this form a few days before your appointment.

Name: ______ Pre-op: ______ Complete PX ______ PN ______
Address: ______ Appt.: ______ Time: ______
Date of birth: ______ Phone: ______ Dr. ______

FAMILY HISTORY

	If Living Age	Health	If Deceased Age At death	Cause	Has any blood relative ever had:	Please check No	Yes	Who
Father					Heart disease			
Mother					Cancer			
Brothers					Glaucoma			
					Sugar diabetes			
					Tuberculosis			
					Nervous disorder			
Sisters					Epilepsy			
					Allergy			
					Stroke			
					Hardening of the arteries			
					High blood pressure			
					Anemia			

Weight
Present ______
One year ago ______

Immunizations	Date
Tetanus	
Smallpox	
Oral Polio	

PERSONAL HISTORY

Have you ever had: (please check)

	No	Yes		No	Yes		No	Yes
Measles			Polio			High blood pressure		
Mumps			Meningitis			Nervous breakdown		
German measles			Kidney disease			Hay fever		
Scarlet fever			Gonorrhea			Asthma		
Diphtheria			Syphilis			Ulcer		
Pneumonia			Anemia			Prostate trouble		
Pleurisy			Yellow jaundice			Spastic bowel		
Rheumatic fever			Epilepsy			Nervous stomach		
Heart disease			Migraine			Kidney stone		
Arthritis			Tuberculosis			Gall stones		
Rheumatism			Sugar diabetes			Hemorrhoids		
			Cancer					

LIST ALL HOSPITALIZATIONS

Reason	Year	Hospital	Doctor

ALLERGIES	No	Yes
Penicillin, Sulfa		
Other antibiotics		
Aspirin, codeine		
Other drugs		
Any foods		

HABITS

Coffee: ______ cups/day
Cigarettes: ______ per day
Alcohol:
Never ☐ Rarely ☐
Moderate ☐ Daily ☐
Medicines:
Yes ☐ No ☐

WOMEN ONLY

Menstrual history

Age at onset ______
Cycle ______ days (period to period)
Duration ______ days
Are periods regular? No ☐ Yes ☐
Heavy ☐ Medium ☐ Light ☐
Spotting between periods? No ☐ Yes ☐
Headaches? No ☐ Yes ☐
Cramps? No ☐ Yes ☐
Bleeding after intercourse? No ☐ Yes ☐
Date of last period ______
Date of last pap smear ______
Pregnancies—How many ______
Number of children ______
Number of miscarriages ______
Number of stillbirths ______
Any trouble with pregnancy? No ☐ Yes ☐

Name ______________________________ Date ____________

Address ______________________________ Age ____________

CURRENT REVIEW OF SYMPTOMS

	No	Yes	How Long?
Fading Vision			
Halos Around Lights			
Double Vision			
Earaches			
Ear Drainage			
Loss of Hearing			
Noises in Ears			
Frequent Sore Throats			
Hoarseness			
Swelling in Neck			
Severe Nose Bleeds			
Hay Fever			
Asthma			
Chronic Cough			
Coughing up Blood			
Pain in Chest with Deep Breaths			
Rattling or Wheezing Sounds in Chest			
Frequent Chest or Bronchial Infections			
Shortness of Breath with Exertion			
Swelling of Feet or Ankles			
Sudden Changes in Rate of Heartbeat			
Pain or Pressure in Chest with Exertion			
Awakened at Night Short of Breath			
Nausea or Vomiting			
Vomiting of Blood			
Bloating or Belching Following Meals			
Excessive Gas or Gas Pains			
Indigestion			
Any Change in Bowel Habits			
Blood in or on Bowel Movements			
Use Laxative Regularly			
Difficult Urination			
Pain or Burning on Urination			
Blood in Urine			
Frequent Urge to Empty Bladder			
Up at Night to Pass Urine: How Many Times ______ ?			
Loss of Urine when Straining, Laughing, Coughing, etc.			
Convulsions or Fits			
Nervous Spells			
Fainting Spells			
Attacks of Dizziness			
Do You Worry A Lot?			
Are You A Nervous Person?			
Are You Frequently Unhappy or Depressed?			

What do you consider to be your leading health problem(s) at the present time?

Date of last chest X-Ray ____________________
Result ____________________
Date of last electrocardiogram ____________________
Result ____________________