FAMILY HISTORY

Please check below if any of your immediate relatives have had any of the following and list who

☐ **NO FAMILY MEDICAL HISTORY TO REPORT**

☐ Adopted	☐ Cancer	☐ Hypertension	☐ Stroke
☐ Yes ☐ No	Relation:_____	Relation:_____	Relation:_____
☐ Adverse Reaction to anesthesia	☐ Depression	☐ Osteoarthritis	☐ Other not listed, explain
Relation:_____	Relation:_____	Relation:_____	_____
☐ Bleeding disorders	☐ Diabetes	☐ Osteoporosis	_____
Relation:_____	Relation:_____	Relation:_____	_____
☐ Blood clots/Pulmonary embolism	☐ Heart disease	☐ Rheumatoid arthritis	_____
Relation:_____	Relation:_____	Relation:_____	_____

Social History

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widow/Widower

Hobbies:_____

Smoking: ☐ Never Smoked ☐ Former Smoker ☐ Current Smoker How many packs/day?_____

Do you dip or chew tobacco? Y ☐ N ☐ If Yes, how much per day?_____

Do you drink alcoholic beverages? Y ☐ N ☐ If Yes, how many drinks per week?_____

Do you use recreational drugs? Y ☐ N ☐ If Yes, what and how often?_____

Do you exercise? Y ☐ N ☐ If Yes, how many times per week?_____

Review of Systems *Please check below if you have, or recently experienced, any of these medical conditions*

☐ **NO SYMPTOMS TO REPORT**

Abdominal pain Y ☐ N ☐	Fever/Chills/Night Sweats Y ☐ N ☐	Seizures Y ☐ N ☐
Anxiety Y ☐ N ☐	Fatigue Y ☐ N ☐	Shortness of breath Y ☐ N ☐
Arm/Leg pain Y ☐ N ☐	Gynecological Problems Y ☐ N ☐	Skin wounds/Rashes Y ☐ N ☐
Black, tarry stools Y ☐ N ☐	Impotence Y ☐ N ☐	Swollen glands Y ☐ N ☐
Chest pain Y ☐ N ☐	Incontinence Y ☐ N ☐	Urinating at night Y ☐ N ☐
Dental problems Y ☐ N ☐	Irregular heart rate Y ☐ N ☐	Vision problems Y ☐ N ☐
Depression Y ☐ N ☐	Leg swelling Y ☐ N ☐	Weight gain/loss Y ☐ N ☐
Easy bleeding/Bruising Y ☐ N ☐	Palpitations Y ☐ N ☐	
	Psychological problems Y ☐ N ☐	

List all Known Allergies to Medications ☐ No Medication Allergies

1. _____ Reaction type:_____
2. _____ Reaction type:_____
3. _____ Reaction type:_____

Are you allergic to latex? ☐ Yes ☐ No If so, what is the allergy?_____

Tape allergy? ☐ Yes ☐ No

Current Medications *Include herbal and over-the-counter drugs. List all medications with dosage. Using additional sheet if needed*

☐ **NOT CURRENTLY TAKING MEDICATIONS**

1. _____
2. _____
3. _____
4. _____
5. _____

NAME:_____ **DOB:** _____