

Date _____/_____/_____ Please fill in all fields the best you can. Bring this form to your appointment for your physical.

Name _____ Date of birth _____/_____/_____

Date of procedure _____/_____/_____ Procedure _____

Surgeon _____ Hospital _____

Marital Status: married single divorced widowed long-term partner

Do you have children? Yes No

Alcohol use? Yes No If so average drinks/day _____

Recreation drug use? Yes No

Do you smoke? Yes No If so how much _____

Are you working? Yes No If so job title _____

Have you had any adverse reactions from anesthesia? Yes No

Have you had any reaction to latex? Yes No

Do you have any food allergies? Yes No

If you are female, are you currently pregnant? Yes No

Have you ever had a blood clot in your lungs or leg? Yes No

Do you have family members with bleeding or clotting problems? Yes No

Have you ever required a transfusion with surgery? Yes No

Do you have allergies to medications? Yes No

Do you currently have or have you ever experienced any of the following medical conditions?

| | | | | | |
|---------------------|------------------------------|-----------------------------|---------------------------|------------------------------|-----------------------------|
| Anxiety/Depression | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Heartburn/reflux | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Asthma | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Hepatitis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Blood Clots | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Kidney disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Blood disorders | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Lung disease-other | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Breathing-difficult | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Muscle disorders | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Cancer | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Pacemaker / Defibrillator | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Chest Pain | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Rheumatic disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Seizure disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Fainting spells | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Sleep apnea | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| HIV | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Stroke | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart Attack | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Tuberculosis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart disease-other | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | |

Past and Present Medical Diseases not listed above:

List any unusual childhood illnesses

1. _____

2. _____

3. _____

4. _____

Current Medications:

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Past Hospitalization and Surgeries

Date _____ Type of Surgery _____ Complications _____

_____/_____/____ Yes No

_____/_____/____ Yes No

_____/_____/____ Yes No

Physician Notes:

Review of Current Health. *Check those that apply to you*

General

- Unexplained weight loss/weight gain
- Fevers/Chills/Sweats
- Difficulties sleeping
- Change in appetite

Skin

- Unexplained rash
- Persistent itching
- Yellow or discolored skin
- Concerning hair or nail changes
- Excess sun exposure
- History of skin cancer
- Concerning skin lesions/mole

Head

- History of headaches
- History of head trauma

Eyes

- Changes in vision
- Last eye exam was _____

Ears

- Hearing changes
- Ringing in the ears
- Chronic ear infections
- Dizziness/Vertigo

Nose

- Runny nose
- Bloody nose
- Nasal congestion

Throat

- Hoarseness of voice
- Sore throat
- Difficulty swallowing

Neck

- Neck stiffness
- Lumps/Bumps in neck

Lungs

- Shortness of breath
- Wheezing
- History of exposure to pollutants:
 - Environment or Occupational
- Cough
- Pain with breathing

Cardiovascular

- Chest pain
- Palpitations/skipped beats
- History of heart murmur
- Dizziness/Fainting spells
- Fluid in legs/feet
- Unable to sleep flat at night
- Waking up in night gasping for air
- Pain in legs with activity

Gastrointestinal

- Nausea/Vomiting
- Diarrhea
- Constipation
- Change in bowel habits
- Pain with defecation
- Heartburn
- Difficulty eating certain foods
- Jet black stool
- Blood in stool
- Abdominal pain

Genitourinary

- Frequency of urination
- Burning with urination
- Blood in urine
- Urinary urgency
- Urine accidents

Women's Health

- Age of first period _____
- I reached menopause at age _____
- Last menstrual period _____
- Irregular menstrual periods
- Vaginal discharge/spotting/unusual odor
- Currently pregnant, _____ months
- Pain with intercourse

Women's Health *continued*

- History of sexually transmitted diseases
- Breast lumps/bumps/nipple discharge
- Breast skin lesions; dryness/scaling/redness
- Breast pain

Men's Health

- Erectile dysfunction
- Difficulty with ejaculation
- Skin lesions on penis
- Blood in sperm
- History of prostrate problems
- Urgency/Frequency/Burning w/ urination
- Premature ejaculation

Behavioral Health

- Mood changes
- Anxiety/Depression
- Insomnia
- Suicidal ideation
- Hallucinations

Neurological Health

- Numbness/tingling sensations in extremities
- Decrease strength in extremities
- Seizures
- History of stroke
- Neurological disease

Musculoskeletal

- Muscle weakness/pain
- Joint pain/redness/swelling
- Back/neck pain
- Muscle spasm

Others

- Easy bruising
- Excessive bleeding time
- Hot/cold intolerance
- Excessive thirst/hunger

Family History

Please list any illness in your family members such as heart disease, heart attacks, heart surgery, diabetes, cancer (and type), high cholesterol, high blood pressure, liver or kidney disease, lung disease, anxiety or depression, suicide.

| | Current Age | Diseases | Age Died |
|----------|-------------|----------|----------|
| Father | | | |
| Mother | | | |
| Siblings | | | |
| | | | |
| | | | |
| | | | |
| | | | |