Past Medical History

Diabetes ☐ Yes ☐ No Comments	Kidney Disease ☐ Yes ☐ No Comments	Blood Clots legs/lung ☐ Yes ☐ No Comments
High Blood Pressure ☐ Yes ☐ No Comments	Urinary Tract Infection ☐ Yes ☐ No Comments	Neurologic/Epilepsy ☐ Yes ☐ No Comment
Heart Disease ☐ Yes ☐ No Comment	Thyroid Dysfunction ☐ Yes ☐ No Comment	Gastrointestinal-Reflux/ Crohn's ☐ Yes ☐ No Comment
Rheumatic Fever ☐ Yes ☐ No Comment	Tuberculosis ☐ Yes ☐ No Comments	Hepatitis/Liver Disease ☐ Yes ☐ No Comments
Mitral Valve Prolapse ☐ Yes ☐ No Comments	Asthma ☐ Yes ☐ No Comments	Other ☐ Yes ☐ No Comments
Psychiatric ☐ Yes ☐ No Comments	Anesthesia Complications ☐ Yes ☐ No Comments	Other ☐ Yes ☐ No Comments

Hospitalizations (reason & year)	PROVIDER'S NOTES
1.	
2.	
Past Surgical History (include cosmetic procedures)	

1.	4.	7.
2.	5.	8.

Family History

Mother: ☐ Living ☐ Deceased: Cause of death________________	Sibling: ☐ Living ☐ Deceased: Cause of death________________
Father: ☐ Living ☐ Deceased: Cause of death________________	Sibling: ☐ Living ☐ Deceased: Cause of death________________
Breast Cancer ☐ Yes ☐ No Who:	Anesthesia Complications ☐ Yes ☐ No Who:
Ovarian Cancer ☐ Yes ☐ No Who:	Birth Defects/Hereditary Disorders ☐ Yes ☐ No Who;
Colon Cancer ☐ Yes ☐ No Who:	Heart Disease ☐ Yes ☐ No Who
Uterine Cancer ☐ Yes ☐ No Who:	High Blood Pressure ☐ Yes ☐ No Who:
Osteoporosis ☐ Yes ☐ No Who:	Diabetes ☐ Yes ☐ No Who:
Gynecological Problems ☐ Yes ☐ No Who:	Psychiatric Disorder ☐ Yes ☐ No Who

Social History

Marital Status: ☐ single ☐ married ☐ separated ☐ divorced ☐ widow ☐ other	
Occupation	Social Drug Use ☐ Yes ☐ No Type: Amount: How often:
Cigarettes ☐ Yes ☐ No Pack/day: For how long: Quit Date:	Abuse/Domestic Violence ☐ Yes ☐ No Past or Present Relationship
Alcohol ☐ Yes ☐ No Type: Amount: How often:	Advance Directives ☐ Yes ☐ No If yes please bring a copy for your chart ☐ Yes ☐ No

Review of Systems (Check all that apply and explain if necessary)

Constitutional ☐ Weight loss ☐ Fever ☐ Fatigue ☐ Weight gain ☐ other	Genitourinary ☐ Burning with urination ☐ Blood in urine ☐ Voids/night ☐ urinary frequency/urgency ☐ caffeine/day ☐ other
Neck ☐ Pain ☐ difficulty swallowing ☐ Lumps ☐ other	Skin/Breast ☐ Rash ☐ Lumps in Breast ☐ Nipple discharge ☐ Pain in Breast ☐ other
Cardiovascular ☐ Palpitations (Rapid heart rate) ☐ Irregular heart beat ☐ Chest pain ☐ Shortness of breath ☐ other	Neurological ☐ Frequent Headaches ☐ Dizziness ☐ Weakness ☐ Numbness/ Tingling where? ☐ Other
Abdomen ☐ Pain ☐ Bloating ☐ Blood in Stool ☐ Constipation ☐ Diarrhea ☐ Poor appetite ☐ Other	Psychiatric ☐ Insomnia ☐ Depression ☐ Anxiety ☐ Moodiness ☐ other
Endocrine ☐ Night sweats ☐ Hot flashes ☐ Memory loss ☐ dry skin ☐ Other	