

MEDICAL HISTORY / REVIEW OF SYSTEMS

Please check if you have a history of any of the following:	YES	NO		YES	NO
GENERAL			CARDIOVASCULAR		
Are you currently pregnant?			Chest Pain/Angina		
Diabetes			Heart Attack/Myocardial Infarction		
Stroke			Palpitations		
Kidney Disease			High Blood Pressure / Hypertension		
Ulcers			Shortness of Breath		
Asthma or Lung Disease			Swelling of Lower Extremities		
Cancer: Type?			HEMATOLOGIC		
Fatigue			Anemia		
Weakness			Blood Clots		
Fevers			Bleeding Tendency		
Skin problems/disorders: Type?			Easily Bruised		
Rheumatic Fever			Circulatory Problems		
Tuberculosis			Currently on Blood Thinners		
Recent weight gain/loss: (circle one) How much?			If yes, what type?		
BLOODBORNE PATHOGENS			Phlebitis		
HIV / AIDS			MUSCULOSKELETAL		
Hepatitis			Joint Pain		
Other			Joint Swelling		
SITES OF INFECTION			Muscle Weakness		
Urinary			Muscle Tenderness		
Dental			Morning Stiffness		
Other			Arthritis / Osteoarthritis		
NEUROLOGICAL			Rheumatoid Arthritis Bunions		
Headaches			Osteoporosis		
Dizziness			Bone / Joint Infections		
Fainting			Gout		
Memory Loss			PSYCHOLOGICAL		
Loss of Consciousness			Depression		
Muscle Spasms			Anxiety Disorder		
Numbness or Tingling of Hands/Feet			Other		
Blindness or Trouble Seeing					
Deafness or Trouble Hearing					
Seizures					

Other illnesses or diseases which are not listed? Please describe:

FAMILY HISTORY

Please check if any of your family (parents, brothers, sisters, grandparents) have a history of any of the following:

	YES	NO		YES	NO
Diabetes (sugar)			Abnormal Bleeding Tendencies		
Heart Disease			Rheumatoid Arthritis		
Anesthetic Complications			Osteoarthritis		
Cancer: Type?			Gout		

SOCIAL HISTORY

What is your approximate weight? lbs. Height Ft. in.

Occupation: _____ Job Duties: _____

Are you (circle one) right handed left handed

Do you currently smoke? Yes No
 If yes or in past, # packs per day? _____ # of years? _____

Do you consume alcohol? Yes No If so, how many drinks per week?
 Is there a history of abuse? Yes No

Have you ever had a problem with drugs? Yes No

Do you participate in recreational drugs? Yes No
 If yes, or in past, list type and amount.

Please list all sports & hobbies you are involved in:

I, as the patient, state the information is correct and accurate to the best of my knowledge.

Patient Signature: _____ **Date:** _____