Family History

Problem:	Does it run in your family?		Family Member(s) who have had this health issue.
Diabetes	❑ Yes	❑ No	_____
Heart Disease	❑ Yes	❑ No	_____
Asthma	❑ Yes	❑ No	_____
Blood Clots	❑ Yes	❑ No	_____
Arthritis	❑ Yes	❑ No	_____
Hip Problems	❑ Yes	❑ No	_____
Cancer	❑ Yes	❑ No	_____

Social History

Occupation: Current: _____ ❑ Disabled Reason for Disability: _____

Past: _____ ❑ Retired _____

Do you live alone? ❑ Yes ❑ No With Whom: _____

Do you smoke? ❑ Yes ❑ No _____ Packs / Day Quit: _____ Months Ago _____ Years Ago

Do you drink alcohol? ❑ Yes ❑ No ❑ Daily ❑ Weekly ❑ Monthly ❑ Infrequently

Any substance abuse? ❑ Yes ❑ No Please List: _____

Review of Systems:

Please circle any that apply.

General	Weight Loss	Weight Gain	Fatigue	Decreased Appetite
	Chills	Fever	Sweats	
Eyes	Blurred Vision	Pain	Sore	Vision Loss
	Glaucoma	Glasses	Contacts	
Ear, Nose, Throat	Hearing Loss	Sore	Inflammation	Dentures
Cardiovascular	High Cholesterol	Chest Pain	Palpitations	Heart Murmur
	Heart Attack	Aortic Aneurysm	Leg Swelling	Shortness of Breath
Respiratory	Sleep Apnea	Tuberculosis	Pneumonia	COPD
	Emphysema	Wheezing	Sputum	Coughing
Gastrointestinal	Bladder Infections	Burning	Hemorrhoids	Kidney Stones
	Blood in Urine	Incontinence		
Musculoskeletal	Injury	Joint Pain	Muscle Pain	Swelling
Skin	Color Change	Rash	Cellulitis	Breast Problems
	Bruises			
Neurologic	Dizziness	Faint	Numbness	Stroke
	Tingling	Headaches	Bad Balance	Trouble with Memory
Hematologic / Lymph	Leukemia	Edema	Anemia	Bleeding Disorders
Immunological	HIV	AIDS	Hepatitis	Sexually Transmitted Diseases
Psychological	Depression	Anxiety	Manic	Personality Disorders
	Night Sweats	Sleep Disturbances		
Other: _____				

Misc. Information

Please list anymore information that may be important to your visit today.

_____

_____

Signatures

Patient Signature: _____ ___ / ___/___

Reviewed By Staff: Reviewed By Staff:

Clinical Staff: _____ ___/___/___ Pre-Op Staff: _____ ___/___/___