

DATE:

NAME:

REFERRED BY:**PRESENT PROBLEM:****ALLERGIES:**

- Environmental:
- Medications:

MEDICATIONS (Please list all):

- Birth control/Hormones

PREVIOUS SURGERY:**ILLNESS:**

- | | |
|--|--|
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Transfusions |
| <input type="radio"/> Heart Disease | <input type="radio"/> Phlebitis (inflamed leg veins) |
| <input type="radio"/> Artificial Valves/Pacemaker | <input type="radio"/> Artificial Joints |
| <input type="radio"/> Hepatitis | <input type="radio"/> Autoimmune disease |
| <input type="radio"/> Mononucleosis | <input type="radio"/> Rheumatoid Arthritis |
| <input type="radio"/> Thyroid Disease | <input type="radio"/> LUPUS |
| <input type="radio"/> Peptic Ulcer | <input type="radio"/> Scleroderma |
| <input type="radio"/> Gall Bladder Disease | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Tuberculosis | <input type="radio"/> Kidney Stones |
| <input type="radio"/> Malaria | <input type="radio"/> Kidney Infection |
| <input type="radio"/> HIV Risk | <input type="radio"/> Cold Sores |
| <input type="radio"/> Immunosuppression | <input type="radio"/> Motion Sickness |
| <input type="radio"/> Diabetes | <input type="radio"/> Sleep Apnea |
| <input type="radio"/> Prednisone/Steroid Sensitivity | <input type="radio"/> Other |

FAMILY HISTORY:

- | | |
|-------------------------------------|--|
| <input type="radio"/> Breast Cancer | <input type="radio"/> Strokes |
| <input type="radio"/> Skin Cancer | <input type="radio"/> Autoimmune Disease |
| <input type="radio"/> Melanoma | <input type="radio"/> Rheumatoid Arthritis |
| <input type="radio"/> Heart Disease | <input type="radio"/> Cleft Lip & Palate |
| <input type="radio"/> Diabetes | <input type="radio"/> Other |

BLEEDING TENDENCIES:

- | | |
|--|---|
| <input type="radio"/> Do you take aspirin? | <input type="radio"/> Vitamin- E |
| <input type="radio"/> Ibuprofen (Motrin, Advil, Nuprin) | <input type="radio"/> Other Anti-inflammatory medication (Naprosyn, Feldene, Clinoril, etc.) |

GYN HISTORY: Pregnancies?

Did you breast feed your children?

OTHER:

- | | | |
|-------------------------------|-------------------------------|-----------------------------------|
| <input type="radio"/> Tobacco | <input type="radio"/> Alcohol | <input type="radio"/> Other drugs |
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OCCUPATION: