

## SOCIAL HISTORY

Single     Married     Divorced     Widowed     Other \_\_\_\_\_  
Living with:     Alone     Spouse     Parents     Friend     Other \_\_\_\_\_  
Current Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Who will take care of you following surgery? \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_  
What is your daily consumption of the following?  
Coffee \_\_\_\_\_ Alcohol \_\_\_\_\_ Tobacco \_\_\_\_\_ Mind altering drugs \_\_\_\_\_

## FAMILY MEDICAL HISTORY

Has a family member ever had the problem for which you are now coming to this office?     Yes     No

If yes, please explain: \_\_\_\_\_

### Has a family member had:

Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood/Bleeding Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma/Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Scleroderma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No

## REVIEW OF BODY SYSTEMS

Do you currently have symptoms of :

Fever, weight loss or fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma or other eye problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear, hearing or balance problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nose or sinus problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty swallowing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart problems (chest pain, palpitations, irregular heartbeat, heart attack)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
High or low blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing problems, asthma, or lung disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems with the reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems with bones, muscles, or joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems of the breasts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurological problems (stroke, numbness, weakness, dizziness, frequent headaches)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been treated for emotional problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes, hypoglycemia, thyroid disease, or endocrine problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise easily or take longer than normal to stop bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatoid or other arthritis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vascular disease, lupus, or scleroderma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling of the lymph nodes or abnormal blood problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does it take you a long time to heal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Could you possibly have an infectious disease and/or MRSA?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take products containing aspirin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have religious beliefs that discourage blood transfusions?	<input type="checkbox"/> Yes <input type="checkbox"/> No

My dominant hand is:     Right     Left     Both

*I certify that the above is true, correct and complete. I am aware and accept that withholding information about my medical history could result in serious injury to me or harm to those involved in my care.*

Signed: \_\_\_\_\_ Witnessed: \_\_\_\_\_