

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone Number \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Other treating Physicians \_\_\_\_\_

History of Present Illness (Describe all in detail what is bothering you, when started, treatments, tests performed)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Medical History (List all hospitalizations and illnesses for which you have been treated, e.g. diabetes, hypertension, heart disease, lung disorders, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Surgical History (List all operations and major injuries)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies and Adverse Reactions (Include allergies to antibiotics, Latex, X-ray, dye, skin preps, pain medications if applicable)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Blood Transfusions: I will accept blood products in an emergency 1. YES \_\_\_\_\_ 2. NO \_\_\_\_\_  
Have you ever had transfusion reactions? 3. YES \_\_\_\_\_ 4. NO \_\_\_\_\_

Current Medications (Include insulin, steroids, inhalers, oxygen, eye drops, etc.)

Drug	Dose	Frequency	Drug	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**SOCIAL HISTORY (Circle all that apply)**

Marital Status: 1. Single 2. Married with \_\_\_ children 3. Divorced since \_\_\_\_\_ 4. Widowed since \_\_\_\_\_

Living Will: YES NO

Occupation: \_\_\_\_\_

Tobacco: 1. None 2. Currently smoke \_\_\_\_\_ packs/day and have done so for \_\_\_\_\_ years  
3. Previously smoked \_\_\_\_\_ packs/day for \_\_\_\_\_ years. Stopped in \_\_\_\_\_ 4. Smokeless tobacco

Alcohol: 1. None 2. Minimal 3. Moderate 4. Heavy 5. Previously Heavy

Caffeine: 1. None 2. 1-3 servings daily 3. 4-6 servings daily 4. More than 6 servings daily

Drug Use: 1. Marijuana 2. Cocaine 3. Crack 4. Heroin 5. Other (list) \_\_\_\_\_

Family History (Please include history of diabetes, heart disease, hypertension, or cancer)

	ALIVE/DECEASED	AGE	HEALTH PROBLEMS/CAUSE OF DEATH
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers/Sisters	_____	_____	_____

Is there a family history of breast or ovarian cancer? (who, at what age, breast or ovarian)  
\_\_\_\_\_