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Chandler, AZ 85224
(480) 963-3034
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Date: _____

Name: _____ Date of Birth: _____

Referring Doctor: _____ Family Doctor: _____

List all ALLERGIES to medicines, latex, adhesives, ect.: (If none, please circle NKDA)

Do you take:	Yes	No	If Yes, explain:
Aspirin regularly	_____	_____	_____
Blood Thinners (ie: Plavix, Coumadin, ect.)	_____	_____	_____
Steroids (ie: Prednisone, Cortisone, ect.)	_____	_____	_____
Hormones (ie: Premarin, ect.)	_____	_____	_____

List all MEDICATIONS, dose frequency and reason for use: (continue on reverse side if necessary)

Medicine	Dose & How Often	Reason for use
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

List ALL Previous Operations/Procedures:

Procedure	When	Where
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Cancer Treatment: (Have you had Chemotherapy or Radiation Therapy?)

Type	When	By Whom
1. _____	_____	_____
2. _____	_____	_____

Have you had any adverse reactions to anesthesia? Yes _____ No _____

If yes, explain: _____

Do you have any bleeding tendency or clotting disorder? Yes _____ No _____

If yes, explain: _____

Social History: Yes No If yes, How much & How often

Do you smoke or chew tobacco? _____

Do you drink alcoholic beverages? _____

Do you drink caffeinated coffee, tea, soda? _____

Do you use any recreational or IV drugs? _____

If yes, please explain what types and how often: _____

Past Medical History: (Check the boxes that apply, describe below and list dates if possible)

Stroke	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	HIV Infection	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	T.B.	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	Lymphedema	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Lymphoma	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Depression/Anxiety, ect.	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Neuro/Muscular Disease	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Other	<input type="checkbox"/>

Explain:

Family History: List diseases (including specific types of cancer) that run in the family.

Disease	Relative	At what approximate age
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

ROS: List all symptoms that you are experiencing currently

<u>General</u>	Yes	No	<u>Heart</u>	Yes	No
Weakness	___	___	Chest Pain	___	___
Weight Loss	___	___	Heart Attack	___	___
Fever/Chills	___	___	Irregular Heart Beat	___	___
Night Sweats	___	___	Heart Failure	___	___
			Swelling in Ankles	___	___
<u>Eyes</u>	Yes	No	Palpitations	___	___
Vision Changes	___	___			
Double Vision	___	___	<u>Musculoskeletal</u>	Yes	No
Corrected Vision	___	___	New Aches/Pains in		
			Muscle/Joints	___	___
<u>Head/Neck</u>	Yes	No	Arthritis	___	___
Headache	___	___			
Blackout Spells	___	___	<u>Gastrointestinal</u>	Yes	No
Changes in Hearing	___	___	Abdominal Pain	___	___
Changes in Taste/Smell	___	___	Nausea/Vomiting	___	___
			Vomit Blood	___	___
<u>Hematologic</u>	Yes	No	Difficulty Swallowing	___	___
Anemia	___	___	Heartburn/Indigestion	___	___
Easy Bruising	___	___	Blood in Stool	___	___
Clotting Problem	___	___	Black/Tarry Stool	___	___
			Change in stool size/color	___	___
<u>Lung</u>	Yes	No	Constipation	___	___
Lung Problems	___	___	Yellow Jaundice	___	___
Shortness of Breath	___	___			
Cough Up Blood	___	___	<u>Kidney</u>	Yes	No
Wheezing/Asthma	___	___	Blood in Urine	___	___
Pneumonia	___	___	Kidney/Bladder Infection	___	___
Tuberculosis	___	___	Kidney Stones	___	___
			Painful Urination	___	___
			Difficulty Urinating	___	___
<u>Breast</u>	Yes	No	<u>Neurologic</u>	Yes	No
Lump	___	___	Tingling	___	___
Nipple Discharge	___	___	Numbness	___	___
Pain	___	___	Weakness	___	___
Date Last Mammogram	_____				

Reproductive History Yes No
 Age at 1st Period _____
 Age at Menopause _____
 # of Pregnancies _____
 # of Live Birth _____
 Last Menstrual Period _____
 Last Pap Smear _____
 Birth Control Pills _____
 Hormone Pills _____

Psychiatric Yes No
 Depression _____
 Anxiety _____
 Mood Swings _____

Skin Yes No
 Rash _____
 Skin Cancer _____
 Change in Mole _____

For Bariatric Patients Only:

Diets used and weight lost: _____

Sustained weight loss: _____ How long was weight lost? _____

How long over 100lbs. overweight? _____ How many times have you lost over 25lbs.? _____

How long have you been overweight? _____

Are you currently under a physician's care for weight loss? ___ Yes ___ No

Physician's Name _____ Address: _____

Physician Comments:

Physician Signature: _____

Date: _____