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)

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

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____

Past Surgical History (List all operations and major injuries)

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

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____

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)

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