Patient Name: _____

LIST **ALL** *MEDICAL PROBLEMS* AND ALL *SURGERY* YOU HAVE UNDERGONE WITH DATES

_____

_____

_____

How did you tolerate the anesthesia? _____

Were you satisfied with the results? ____Yes ____No If not, why not? _____

ALLERGY ARE YOU ALLERGIC TO **ANY** MEDICINES? **WHICH ONES?** ***& what is your reaction?***

_____

Are you taking any medications? Include **BIRTH CONTROL PILLS, VITAMINS, HERBALS, SUPPLEMENTS, DOSAGE AND FREQUENCY. Include over-the-counter medicines.** (i.e.) Tylenol 325mg every 4 hours

_____ _____ _____

_____ _____ _____

_____ _____ _____

Name of Family Physician/Pediatrician: _____ Address/Phone: _____

Name of Internist/Cardiologist: _____ Address/Phone: _____

Name of Pulmonologist: _____ Address/Phone: _____

Name of OB/GYN or Dermatologist: _____ Address/Phone: _____

NO YES May we contact him/her for any medical issues that may arise?
NO YES Do you exercise on a regularly? What type of activity & how often? _____

SOCIAL HISTORY

No Yes Do you smoke cigarettes and/or cigars? How many cigarettes/cigars per day? _____ If you have quit, When_____

No Yes Do you drink coffee? Caffeinated ◯ Decaf ☐ If so, how many cups a day? _____

No Yes Are you a singer, amateur or professional? How often? _____

No Yes Do you consume Beer ☐ Liquor ◯ How many a day or weekend? (Quantity) _____

Are you on one of these medications? Viagra Cialis Levitra Coumidin (warfarin) Plavix Aspirin Fish oil Vitamin E

Father: Age____ Alive ____ Deceased____ If deceased, cause of death_____
Mother: Age____ Alive ____ Deceased____ If deceased, cause of death_____
Spouse: Age____ Alive ____ Deceased____ If deceased, cause of death_____
Siblings: Age____ Alive ____ Deceased____ If deceased, cause of death_____
Siblings: Age____ Alive ____ Deceased____ If deceased, cause of death_____
Siblings: Age____ Alive ____ Deceased____ If deceased, cause of death_____
Siblings: Age____ Alive ____ Deceased____ If deceased, cause of death_____

Signature: _____ **Date** _____

Patient Name: _____

Do *You* or any family members have (Indicate you or particular family member)

Heart problems_____ Asthma_____ Sleep apnea _____
Tuberculosis_____ High blood pressure_____ Excessive bruising_____
Excessive scarring_____ Diabetes_____ Thyroid problems_____
Bleeding problems_____ Hearing loss _____ Hepatitis_____
Do you take antibiotics prior to dental procedures? YES NO OTHER:_____

Review of Systems: *Circle every issue that you experience. If none apply, place a (-) next to the category.*

General/Constitutional- SLEEP APNEA. Snoring, weight loss or gain, fatigue, fever, night sweats, chills, decreased strength, difficulty conducting usual activities, exercise intolerance.

Skin/Breast - Rash, itching, pigmentation, moisture or dryness, texture changes, changes in hair growth or loss, nail changes. Breast lumps, tenderness, swelling, nipple discharge

Eyes/Ears/Nose/Mouth/Throat- Headaches, spinning sensation, lightheadedness, injury, double vision, tearing, blind spots. Nose bleeding, colds, discharge. Gum bleeding, dentures, Neck stiffness, pain, tenderness, masses in thyroid.

Cardiovascular- Chest pain, palpitations, fainting, shortness of breath on exertion or laying flat, hypertension, heart murmurs, varicose veins with pain, calf pain at rest.

Respiratory - Pain, shortness of breath, wheezing, stridor, cough, coughing blood, respiratory infections, tuberculosis (or exposure to tuberculosis).

GastroIntestinal - Poor appetite, foreign body sensation in your throat, difficulty swallowing, indigestion, food allergy, abdominal pain, heartburn, nausea, vomiting, vomiting blood, jaundice, constipation, or diarrhea, abnormal stools (clay-colored, tarry, bloody, greasy), increased flatulence, hemorrholds, recent changes in bowel habits

Genitourinary-Urgency, frequency, pain, night time frequency, blood in urine, , unusual (or change in) color of urine, stones, infections, kidney pain, hesitancy, change in size of stream, dribbling, incontinence, change in libido, potency, genital stores, discharge, venereal disease. **(Female)**- irregularity, last period, menstrual pain, abnormal bleeding, skipped periods, vaginal discharge, post-menopausal bleeding, intercourse pain.

Musculoskeletal- Pain, swelling, redness or heat of muscles or joints, limitation of motion, pain with normal movements, muscular weakness, atrophy, cramps.

Neurologic/Psychiatric- Convulsions, paralyses, tremor, incoordination, numbness, difficulties with memory of speech, sensory or motor disturbances. Nervousness , emotional problems, anxiety, depression, previous psychiatric care, unusual perceptions, hallucinations.

Allergic/Immunologic/Lymphatic/Endocrine- Reactions to drugs, food, insects, skin rashes, trouble breathing. Anemia, bleeding tendency, previous transfusions and reactions. Lymph node enlargement or tenderness, hormone therapy, growth, secondary sexual development, intolerance to heat or cold.

For Women only

NO YES Have you taken hormones (estrogens, progesterones, BCP) or thyroid medication? (Circle all that apply) _____

NO YES **Is there a possibility of pregnancy at this time? Tested by Home pregnancy test or Gynecologist? (Circle appropriate answer)**

NO YES Do you have a history of gynecological problems now or previously? Explain_____

When was your last menstrual period? Date: _____

Number of Pregnancies: _____ Miscarriages_____ Abortions:_____

"Thank you for providing the essential information in this comprehensive evaluation. Your cooperation is appreciated. Write down any questions you may have so that we may discuss them in detail during your visit."

Signature: _____ **Date** _____