

### Past Medical History

Diabetes Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Clots Leg/Lung Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary Tract Infections Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurologic/Epilepsy Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Dysfunction Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis/Liver Disease Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	In Utero DES Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatric Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anesthesia Complications Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Immunization History</b> Have you been vaccinated against Hepatitis B? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you been vaccinated against Influenza? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you been vaccinated against Pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you been vaccinated against Tetanus? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had chicken pox? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had Rubella (German Measles)? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had a TB skin test? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, have you been vaccinated? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, have you been vaccinated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> positive or <input type="checkbox"/> negative.					
Surgeries (Reason & Year)		Hospitalizations (Reason & Year)			
1		5		1	
2		6		2	
3		7		3	
4		8		4	

### Family History

Breast Cancer Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anesthesia Complications Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ovarian Cancer Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Defects/Hereditary Disorders Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Uterine Cancer Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colon Cancer Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Osteoporosis Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gynecological Problems Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Disorder Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Social History

Occupation	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Social Drug Use <input type="checkbox"/> Yes <input type="checkbox"/> No Amount:	Type: How often:
Cigarettes <input type="checkbox"/> Yes <input type="checkbox"/> No For how long:	Pack/day: Quit date:	Abuse/Domestic Violence <input type="checkbox"/> Yes <input type="checkbox"/> No Past or Present Relationship	
Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No Amount:	Type: How often:		
Carbonated Beverage <input type="checkbox"/> Yes <input type="checkbox"/> No Amount:		Weight Bearing Exercise <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency:	

### Physical Complaints within the last year (Check all that apply and explain if necessary)

<b>Constitutional</b> <input type="checkbox"/> Weight Loss <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Other	<b>Genitourinary</b> <input type="checkbox"/> Burning with urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Urinary frequency/urgency <input type="checkbox"/> Other
<b>Neck</b> <input type="checkbox"/> Pain <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Lumps <input type="checkbox"/> Other	<b>Skin/Breast</b> <input type="checkbox"/> Rash <input type="checkbox"/> Lumps in breast <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Pain in breast <input type="checkbox"/> Other
<b>Cardiovascular</b> <input type="checkbox"/> Palpitations (Rapid heart rate) <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Chest pain <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other	<b>Neurological</b> <input type="checkbox"/> Frequent Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Weakness <input type="checkbox"/> Numbness/Tingling where? <input type="checkbox"/> Other
<b>Abdomen</b> <input type="checkbox"/> Pain <input type="checkbox"/> Bloating <input type="checkbox"/> Blood in stool <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Poor appetite <input type="checkbox"/> Other	<b>Psychiatric</b> <input type="checkbox"/> Insomnia <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Moodiness <input type="checkbox"/> Other
<b>Respiratory</b> <input type="checkbox"/> Cough <input type="checkbox"/> Pain with breathing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other	<b>Lymphatic</b> <input type="checkbox"/> Lumps in groin, under arms, or in neck <input type="checkbox"/> Other