Updated 02/2013

Office Use Only: MRN # ______________________________

Health Maintenance

Patient's Name ____ DOB _____________ Date ________________

Present Complaint ____

Medical Doctor _________________________________ Referring Physician ______________________________

Preferred Pharmacy (Please include city and state) ____

Medications and Dosages (may attach list or write on back): ____________________________________

Medication Allergies: ____

Active Problems

Please check ☐ if any of the following are currently active problems for the above named **patient**:

☐ + Latex Allergy Test ☐ Hypertension ☐ Hypothyroidism ☐ Obstructive Sleep Apnea
☐ Glaucoma ☐ Asthma ☐ Osteoporosis ☐ HIV Infection
☐ Allergic Rhinitis ☐ Emphysema ☐ Diabetes ☐ Blood Clotting Problem
☐ Hearing Loss ☐ Stomach Acid Reflux ☐ Arthritis ☐ Cancer (location ___________)
☐ Abnormal Heart Rhythm ☐ Hepatitis ☐ Rheumatoid Arthritis ☐ Using CPAP
☐ Heart Artery Blockage ☐ High Cholesterol ☐ Migraine Headache
☐ Heart Failure ☐ Hyperthyroidism ☐ Seizure
☐ Other Medical Problems ____

Past Medical History

Please check ☐ if the above named **patient** has been treated in the past for any of the following problems:

☐ Heart Attack (year _________) ☐ Hepatitis ☐ Cancer (location _______________) ☐ Stroke
☐ Other past Medical Problems ____

☐ # of Pregnancies _______
☐ # of Children _____
Living: sons_____ dgts_____
Deceased: sons____ dgts______

Past Surgical History

Please check ☐ if the above named **patient** has had anesthesia for any of the following surgeries:

☐ Wisdom tooth extraction ☐ Coronary Artery Bypass ☐ Hernia Repair ☐ Knee Surgery
☐ Pacemaker Placement ☐ Heart Valve Replacement ☐ Kidney Removed ☐ Foot Surgery
☐ Cataract removal ☐ Breast Biopsy ☐ Kidney Stone Removal ☐ Brain Surgery
☐ Ear Surgery ☐ Mastectomy ☐ Hysterectomy ☐ Neck Disc Surgery
☐ Nasal Surgery ☐ Stomach Surgery ☐ Tubal Ligation (Tubes Tied) ☐ Back Disc Surgery
☐ Tonsillectomy ☐ Intestine Surgery ☐ C-section ☐ Carpal Tunnel Repair
☐ Thyroid Surgery ☐ Appendectomy ☐ Shoulder Surgery
☐ Vascular Surgery ☐ Gall Bladder Removal ☐ Hip Surgery
☐ Other Surgeries ____

Past Family History

Please check ☐ if there is a **Family History** for any of the following for the above named patient:

☐ Cancer (Location _____________) ☐ Osteoporosis
☐ Heart Disease ☐ Diabetes
☐ Bleeding Problems ☐ Rheumatoid Arthritis
☐ Hearing Loss ☐ Migraine Headache ☐ Mental Retardation
☐ Seasonal Allergies ☐ Seizures
☐ Hypertension ☐ Alzheimer's
☐ Blood Clots ☐ Parkinson's
☐ Stroke

Other Family Medical Problems ____

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Patient's Name ____________________________________ DOB ______________ Date __________________

Past Social History

Please check ☐ if any of the following apply to the above named **patient**:

- ☐ Caffeine Use; ___ cups/day
- ☐ No Caffeine Use
- ☐ Tobacco Use; ___ppd for ___ yrs
- ☐ No Tobacco use
- ☐ Stopped smoking (date :_____)
- ☐ Alcohol use: ☐ social drinker
  - ☐ 2 drinks/day or fewer
  - ☐ > 2 drinks/day
- ☐ Drug use
- ☐ Second hand tobacco exposure

Review of Systems

Please check ☐ if the above named patient frequently experiences any of the following symptoms:

- ☐ feeling tired
- ☐ fever
- ☐ sweating
- ☐ recent weight loss
- ☐ headache
- ☐ eye symptoms
- ☐ loss of hearing
- ☐ earache
- ☐ ringing in the ears
- ☐ nasal discharge containing pus
- ☐ nasal passage blockage
- ☐ snoring
- ☐ sneezing
- ☐ hoarseness
- ☐ sore throat
- ☐ chest pain
- ☐ palpitations
- ☐ difficulty breathing
- ☐ cough
- ☐ wheezing
- ☐ difficulty swallowing
- ☐ heartburn
- ☐ nausea
- ☐ abdominal pain
- ☐ black or tarry stools
- ☐ pain during urination
- ☐ muscle weakness
- ☐ rash
- ☐ joint pains
- ☐ swelling
- ☐ leg cramps
- ☐ dizziness
- ☐ fainting
- ☐ tingling
- ☐ numbness
- ☐ anxiety
- ☐ depression