



**Please list any previous surgery**

DATE (APPROXIMATE)	TYPE OF SURGERY	HOSPITAL

Do you smoke cigarettes?  yes  no If yes, how many packs per day: \_\_\_\_\_, How many years: \_\_\_\_\_

quit smoking \_\_\_\_\_ years ago  never smoked

Please check any other tobacco products you use:  cigars  pipe tobacco  chew tobacco

Do you drink alcohol?  yes  no If yes, What type: \_\_\_\_\_, How often: \_\_\_\_\_

Do you use any recreational or street drugs?  yes  no If yes, what type: \_\_\_\_\_, How often: \_\_\_\_\_

**Family Medical History**

Cancer  COPD or Asthma  Heart Disease  High Blood Pressure or Stroke  Kidney Disease  Other

Medical History (please check all that apply to you now or in the past)

**Cardiovascular:**

- Yes No
- Rheumatic fever
  - Heart murmur
  - Palpitations
  - Irregular heart beat
  - Chest pain
  - Heart attack
  - High blood pressure
  - Heart failure
  - High cholesterol
  - Stroke/Mini stroke (TIA)
  - Blood clots (DVT)
  - Pulmonary emboli
  - Varicose veins
  - Pain in legs with walking
  - Bruising/bleeding tendency
  - Aneurysms

**Gastrointestinal:**

- Yes No
- Stomach ulcers
  - Gastric reflux/heartburn
  - Hepatitis (specify A, B, C)
  - Liver disease
  - Blood in stool
  - Black (tarry) stool
  - Constipation
  - Diarrhea
  - Change in bowel movements
  - Abdominal pain
  - Nausea/Vomiting
  - Crohns disease
  - Irritable bowel syndrome
  - Ulcerative colitis
  - Colon cancer

**Genitourinary:**

- Yes No
- Frequent urination
  - Nighttime urinary frequency
  - Burning with urination
  - Blood in urine
  - Lack of bladder control
  - Weak urine stream
  - Urinary tract infections
  - Kidney stones
  - Kidney failure
  - Enlarged prostate
  - Prostate cancer
  - Bladder cancer
  - Kidney cancer
  - Testicular cancer
  - Erectile Dysfunction

**Other:**

- Yes No
- Sexually Transmitted Disease (STD)
  - Depression
  - Anxiety
  - Chronic fatigue
  - Fibromyalgia
  - Arthritis
  - Degenerative arthritis
  - Rheumatoid arthritis
  - Glaucoma
  - Thyroid disease
  - Hyperthyroid
  - Hypothyroid
  - Goiter
  - Thyroid cancer
  - HIV/AIDS
  - Diabetes
  - Steroid use
  - Skin cancer
  - Headaches
  - Weight Loss
  - Food Allergies

Please list any other medical problems:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_