

Patient History Form
Continued

Review of Systems

Are you currently having or have you had problems with:

	Circle		Describe all Yes responses:
Eyes	No	Yes	_____
Ears, Nose, Throat	No	Yes	_____
Lungs, Breathing	No	Yes	_____
Digestion	No	Yes	_____
Bowel Movement	No	Yes	_____
Bladder Problem	No	Yes	_____
Diabetes	No	Yes	_____
High Blood Pressure	No	Yes	_____
Bleeding Problems	No	Yes	_____
Balance Problems	No	Yes	_____
Numbness/Tingling	No	Yes	_____
Blackout/Fainting	No	Yes	_____
Psychological Problems	No	Yes	_____
AIDS	No	Yes	_____
Cancer	No	Yes	_____
Arthritis	No	Yes	_____
Polio	No	Yes	_____
TB	No	Yes	_____
Epilepsy	No	Yes	_____

Have you ever had general anesthesia? No Yes
Have any problems with anesthesia? No Yes **If yes, describe:** _____

Social History

Work in the home Employed (occupation _____) Student Retired Daycare
 Single Married Divorced Separated Widowed
Exercise? Daily Monthly Rarely Never

What type of exercise (if applicable): _____

History of substance abuse? No Yes **If Yes, what?** _____

Smoke currently? No Yes _____ Packs per day for _____ years.

Quit Smoking? This year >1 year >5 years >10 years

Previously smoked _____ packs per day for _____ years.

Drink alcohol? Never Daily 1-2 x/week 1-2 x/month 1-2 x/year

Patient Signature (If Patient Is A Minor Parents/Legal Guardian Signature): _____

Today's Date: _____