

Family History (Check all that apply to your biological mother, father or siblings)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Psychiatric disease |
| <input type="checkbox"/> Anesthesia difficulties | <input type="checkbox"/> None | <input type="checkbox"/> Other: _____ | |

Social History

- General education: High School (list name if local) _____
 College _____
 Post graduate or other _____

- Marital Status: Single Married Separated Divorced Widowed

Tobacco use: ___ Packs per day for ___ years If stopped, when _____

Daily Alcohol use: YES NO Amount _____

Other substance use: _____

- Work demands: Sedentary Moderately active Heavy Labor

Do you exercise regularly? YES NO Describe _____

What sports or activities do you participate in?

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Baseball/softball | <input type="checkbox"/> Golf | <input type="checkbox"/> Roller/ice hockey |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Swimming | <input type="checkbox"/> Running/jogging |
| <input type="checkbox"/> Tennis/racquet sports | <input type="checkbox"/> Martial arts | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Track & field | <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Cycling |
| <input type="checkbox"/> Football | <input type="checkbox"/> Soccer | <input type="checkbox"/> Water/snow skiing |
| <input type="checkbox"/> Rugby | <input type="checkbox"/> Lacrosse | <input type="checkbox"/> Aerobics (type _____) |
| <input type="checkbox"/> Other _____ | | |

Current Medical Status/Review of Systems: (Please check all that apply)

- | | | | | |
|------------------------|---|--|--|---|
| Constitutional: | <input type="checkbox"/> Good general health lately | <input type="checkbox"/> Recent weight change | <input type="checkbox"/> Fever | <input type="checkbox"/> Fatigue |
| Eyes: | <input type="checkbox"/> Eye disease/injury | <input type="checkbox"/> Wear glasses/contacts | <input type="checkbox"/> Blurred/double vision | |
| ENT: | <input type="checkbox"/> Hearing loss/ringing | <input type="checkbox"/> Chronic sinus problems | <input type="checkbox"/> Nose bleeds | |
| Cardiovascular: | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Shortness of breath w/walking or lying flat | |
| Respiratory: | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Spitting up blood | <input type="checkbox"/> Chronic/frequent coughs | |
| GI: | <input type="checkbox"/> Diarrhea/constipation | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Change in habits |
| GU: | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Burning/painful urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Bloody urine |
| Muscle/Joint: | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Weakness |
| Skin: | <input type="checkbox"/> Rash/itching | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Chronic skin ulcers | <input type="checkbox"/> Dry skin |
| Neurologic: | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Tremors |
| Psychiatric: | <input type="checkbox"/> Memory loss/confusion | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Depression |
| Hematologic: | <input type="checkbox"/> Slow to heal after cuts | <input type="checkbox"/> Bruising tendency | <input type="checkbox"/> Past blood products transfusions | |