Patient Name/DOB:

Health History

Please Check if you have, or ever had any of the following medical problems

Generalized Symptoms	Yes / No
Anxiety:	❒ ❒
Depression:	❒ ❒
Diabetes:	❒ ❒
Stroke/TIA?	❒ ❒
History of Suicide Attempt	❒ ❒
Seizures:	❒ ❒
Sleep Disorders:	❒ ❒
Anorexia	❒ ❒
Bulemia	❒ ❒
Thyroid - Overactive:	❒ ❒
Thyroid - Underactive:	❒ ❒
MRSA Infection?	❒ ❒
Recent Fever?	❒ ❒
Immune Problem	❒ ❒
AIDS	❒ ❒
Cancer?	❒ ❒
If yes, what type of cancer?	
Sleep Apnea	❒ ❒
Any Keloid Scarring?	❒ ❒

Urinary	Yes / No
Urinating too much/too little?	❒ ❒
Kidney Disorder	❒ ❒
End Stage Renal Disease	❒ ❒

Head / Ear / Nose / Throat	Yes / No
Earaches or Drainage:	❒ ❒
Headache:	❒ ❒
Hearing Loss or Ringing:	❒ ❒
Sinus Problems:	❒ ❒
Vision Changes:	❒ ❒
Dry Eyes	❒ ❒
Excess Tearing	❒ ❒

Respiratory	Yes / No
COPD/Emphysema	❒ ❒
Shortness of Breath:	❒ ❒
Wheezing:	❒ ❒
Recent Pneumonia?	❒ ❒

Cardiovascular	Yes / No
Chest Pain:	❒ ❒
Congestive Heart Failure:	❒ ❒
Heart Attack:	❒ ❒
Heart Murmur:	❒ ❒
High Blood Pressure	❒ ❒
High Cholesterol:	❒ ❒
Anemia	❒ ❒
Pacemaker?	❒ ❒
Heart Valve	❒ ❒
Stent Placed?	❒ ❒

Musculoskeletal	**Yes / No**
Back Pain:	❒ ❒
Joint Pain:	❒ ❒
Muscle Cramps:	❒ ❒

Blood	**Yes / No**
Bleeding Disorder?	❒ ❒
DVT/Blood Clots?	❒ ❒
Pulmonary Embolism?	❒ ❒

Gastrointestinal	**Yes / No**
Abdominal Pain:	❒ ❒
Constipation:	❒ ❒
Diarrhea:	❒ ❒
Heartburn:	❒ ❒
Hepatitis	❒ ❒
Peptic Ulcers	❒ ❒
Weight Loss Surgery?	❒ ❒
Significant Weight Loss?	❒ ❒
Significant Weight Gain?	❒ ❒
If yes: how much?	**lbs**

Gynecologic	**Yes / No**
History of Pregnancy	❒ ❒
If yes: number of children	
Unplanned Miscarriages?	❒ ❒
If yes: how many?	

Abnormal Heart Rhythm or Atrial Fibrillation	❒ ❒

Breast History	**Yes / No**
Breast Pain	❒ ❒
Nipple Discharge	❒ ❒
Breast Rashes	❒ ❒
Shoulder Grooving from Bra?	❒ ❒
Breast Mass?	❒ ❒
History of abnormal mammogram	❒ ❒
Date of Last Mammogram? (Write NA if never had a mammogram)	
History of Breast Cancer?	❒ ❒
Family History of Breast Cancer?	❒ ❒
If yes, who had breast cancer in your family?	
Birth Control or Hormonal Therapy?	❒ ❒
If yes: what type?	

List any other breast issues:

List Any Additional Medical Problems:

List Current Medications AND dosages

List Any Known Allergies: please list drug AND reaction

List Any Past Surgeries and the Date Performed:

List of Significant Family History Medical Problems:

	Yes / No
Family or Personal History of problems with Anesthesia?	❒ ❒
If yes: please explain	

Social History

	Yes / No
Married?	❒ ❒
Smoker?	❒ ❒
If YES, How many years have you smoked?	

Smoked Per Day:

Alcohol - Drinks per Week:

History of Drug Use? (If
yes, list type of drug

	Yes / No
Are You Employed?	❒ ❒

Occupation:

Patient Information

Preferred Phone Number:

Preferred Email

Pharmacy Name - Preferred:

In case of emergency, who can we discuss your care with?

Emergency Contact Name:

Relationship to you:

Phone Number:

	Yes / No
Can we discuss your care with this person? (If NO, they will still be contact in emergency situation.	❒ ❒

How did you hear about us?

What are you interested in discussing today?