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NAME _____ DATE _____

WHAT IS YOUR OCCUPATION? _____

LIST SPORTS OR HOBBIES _____

ARE YOU ALLERGIC TO ANY MEDICATION? YES NO

PLEASE LIST ALL YOU ARE ALLERGIC TO _____

HAVE YOU EVER HAD JAUNDICE, HEPATITIS, OR HAVE BEEN GIVE A BLOOD TRANSFUSION?

YES NO

DATE _____

HAVE YOU EVER HAD SEISURES OR CONVULSIONS? YES NO,

PLEASE EXPLAIN _____

HAVE YOU EVER TAKEN CORTIZONE OR PREDNISONE? YES NO, DATE _____

HAVE YOU EVER HAD A REACTION OR COMPLICATION DUE TO A GENERAL OR LOCAL
ANESTHETIC? YES NO

PLEASE EXPLAIN _____

DO YOU HAVE ANY REASON TO BELIEVE THAT YOU SHOULD NOT BE GIVEN AN ANESTHETIC
OR UNDERGO SURGERY? YES NO, PLEASE EXPLAIN

LIST ANY ILLNESS AND/OR OPERATIONS YOU HAVE HAD IN THE PAST:

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

HT: WT: P: R: B/P: TEMP:

Check all that apply to you

METABOLIC

- Weight Gain
- Weight
- Loss
- Thyroid Disease
- Trouble Sleeping
- Fatigue
- Diabetes
- Changes in Skin
- Excess Body Hair
- Night Sweat

HEENT

- Headaches
- Dizziness
- Failing Vision
- Inflamed Eyes
- Sinus Trouble
- Sore Throat
- Hoarseness
- Nasal Discharge
- Nose Bleeds

MUSCULOSKELETAL

- Arthritis
- Neuritis
- Gout
- Muscle Tightness
Or Spasm
- Muscle Spasm
- Muscle Weakness

RESPIRATORY

- Frequent Cough
- Bronchitis
- Wheezing (Asthma)
- Shortness of Breath
- Severe Chest Pain
- Coughing up Blood
- Smoke How much? _____
- Tuberculosis Exposure

GASTROINTESTINAL

- Nausea
- Vomiting
- Indigestion
- Heartburn of Pain
- Diarrhea
- Constipation
- Blood in Stools
- Mucus in Stools
- Hemorrhoids/Polyps
- Black Stools

CARDIOVASCULAR

- Palpitations
- Waking Short of Breath
- Ankles Swell
- Heart Murmur
- Varicose Veins
- Fainting
- Angina
- 2 or more pillows to sleep
- Leg Cramps
- Enlarged Heart
- High Blood Pressure
- Salt Restrictions
- Heart Skips Beats
- Rheumatic Fever

GENITOURINARY

- Void Frequently
- Incontinence
- Burning on Urination
- Hesitancy
- Kidney Stones
- Urgency to Void
- Void at Night # times
- Blood in Urine
- Bladder Infection
- Kidney Infection

FOR FEMALE PATIENT'S ONLY:

Number of Pregnancies: _____ Number of Live Births _____ Miscarriages _____
 Are your Menstrual Periods Regular? Yes No Do you have heavy periods? Yes No
 Severe Cramping? Yes No Have you gone through menopause? Yes No At what Age? ____
 When was your last pelvic exam? _____ Was a pap smear taken? Yes No When? _____

PERSONAL AND FAMILY HISTORY

	Patient	Family Member (Who)
Stroke	<input type="checkbox"/>	_____
Heart Attack	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	_____

(Patients Signature)

(Date)

Dr. G.K. Aitken

(Date)