

Family History (Close Blood Relatives) - Please check all that apply				
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Neurological
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Mental Illness

Social History				
<input type="checkbox"/> Employed (Occupation) _____		<input type="checkbox"/> Work at Home	<input type="checkbox"/> Student	
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed
Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have children? <input type="checkbox"/> No <input type="checkbox"/> Yes Number: _____		
Exercise? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never		<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> Active
Smoke Currently? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Packs/day for _____ years		Drink Alcohol? <input type="checkbox"/> Daily <input type="checkbox"/> 1-2x/week		
Quit Smoking? <input type="checkbox"/> This Year <input type="checkbox"/> > 1 year <input type="checkbox"/> >5 years <input type="checkbox"/> >10 years		<input type="checkbox"/> 1-2x/month <input type="checkbox"/> 1-2x/year		
Previously Smoked _____ packs per day for _____ years		<input type="checkbox"/> No Alcohol		

Review of Systems - Check all that apply			
Bleeding/Circulation <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Tendency <input type="checkbox"/> Blood Clots <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Sickle Cell <input type="checkbox"/> None	Cancer or Tumor <input type="checkbox"/> Type _____ <input type="checkbox"/> Chemo _____ <input type="checkbox"/> Radiation _____ <input type="checkbox"/> Skin-Basal/Squamous <input type="checkbox"/> Other _____ <input type="checkbox"/> None	Endocrine <input type="checkbox"/> Diabetes Circle: Diet / Pill / Insulin / Pump <input type="checkbox"/> Liver Disease <input type="checkbox"/> Thyroid Problems/Goiter <input type="checkbox"/> Adrenal Disease <input type="checkbox"/> None	Genitourinary <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Prostate/Testicle Problem <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> Difficulty Urinating <input type="checkbox"/> None
Cardiac <input type="checkbox"/> Chest Pain <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Pulmonary Hypertension <input type="checkbox"/> Pacemaker/ICD (Bring your implant card with you) <input type="checkbox"/> Rheumatic Heart <input type="checkbox"/> Rhythm Disturbances <input type="checkbox"/> Irregular Heart Beats <input type="checkbox"/> None	Neurological/Mental Health <input type="checkbox"/> Stroke <input type="checkbox"/> Stroke Mini (TIA) <input type="checkbox"/> Seizures <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Depression/Anxiety <input type="checkbox"/> Emotional Illness <input type="checkbox"/> Claustrophobia <input type="checkbox"/> Panic Attack <input type="checkbox"/> Learning Disabilities <input type="checkbox"/> None	Infectious Diseases <input type="checkbox"/> Recent Mono <input type="checkbox"/> HIV <input type="checkbox"/> Hepatitis <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> C Diff <input type="checkbox"/> None <input type="checkbox"/> Treating Physician? _____	Respiratory <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Emphysema/COPD <input type="checkbox"/> Hoarseness <input type="checkbox"/> Pneumonia <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> CPAP-Y / N ? <input type="checkbox"/> Smoking <input type="checkbox"/> History of Smoking <input type="checkbox"/> Neck Size _____ inches <input type="checkbox"/> TB <input type="checkbox"/> None
Implantable Devices <input type="checkbox"/> Ports/Pumps <input type="checkbox"/> Pacemaker/ICD <input type="checkbox"/> Other (list) _____ _____ <input type="checkbox"/> None	Gastrointestinal <input type="checkbox"/> Recurrent Gastric Reflux <input type="checkbox"/> Hernia <input type="checkbox"/> Ulcers <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> None	Musculoskeletal <input type="checkbox"/> Arthritis <input type="checkbox"/> Circle: Osteo or Rheumatoid <input type="checkbox"/> Gout <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Polio <input type="checkbox"/> Osteopenia <input type="checkbox"/> None	Hearing & Vision <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hearing Aide <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataract <input type="checkbox"/> None
Breast <input type="checkbox"/> Lumps <input type="checkbox"/> Breast Pain	<input type="checkbox"/> Abnormal Mammogram <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> None	Skin <input type="checkbox"/> Rashes, Where? _____ <input type="checkbox"/> Sores/Open Areas <input type="checkbox"/> None	

Have you been hospitalized for any of the above conditions? When? _____ Where? _____

Briefly Explain: _____

Anesthesia?	Yes	NO	?	Explain
Have you ever had anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had a problem with anesthesia including malignant hyperthermia or difficult intubation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Has any member of your family had a problem with anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Loose, capped, or broken teeth, bridges or dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble opening mouth or jaw clicking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have shortness of breath after walking up 2 flights of stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use any street drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what year(s)?
Do you have objections to receiving blood transfusions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have problems with chronic pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Any religious /cultural practices we should know about?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

****Please note: Only complete this section if instructed to do so by WOSM staff.**

Update #1

I have reviewed my health history and confirm that that information listed is complete, correct, and/or I have made the necessary changes to update my health information.

Signature

Date

****Please note: Only complete this section if instructed to do so by WOSM staff.**

Update #2

I have reviewed my health history and confirm that that information listed is complete, correct, and/or I have made the necessary changes to update my health information.

Signature

Date

Office Use Only:

Patient Status:

Healthy

Medically Managed Stable

Major Co-Morbidities

MD Signature: _____

Date: _____

MD Signature: _____

Date: _____

MD Signature: _____

Date: _____