Eastside Medical Group: DATE:_____

Name: _____ Date of Birth: _____Age: _____
Male / Female (circle one) Pregnant Yes / No (circle one)

Reason you are here: _____

SOCIAL HISTORY

_____

Marital Status: □ Single □ Married □ Partner □ Divorced □ Widow/Widower
Children _____ Occupation/Job _____Religion_____

HABITS

_____

Do you dip or chew tobacco? □ Yes □ No If yes, how much per day? _____
Smoking:
□ Never smoked □ Former smoker Date Quit_____ □ Current smoker / How Long? _____Packs per day?_____
Do you drink alcoholic beverages? If yes, how many per week? _____
Do you drink beverages that contain caffeine: (coffee, tea, soda) _____ cups per day
Do you use recreational drugs? If yes, what and how often? _____

CURRENT MEDICATIONS:
Include herbal and over-the-counter drugs. List and name dose. Using additional sheet if needed.
(If you brought a medication list or brought your medications DO NOT FILL OUT)

_____

1. _____ 5._____
2._____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

MEDICATION ALLERGIES: □ **No medication allergies**

Are you allergic to latex? □ **Yes** □ **No**

PAST MEDICAL HISTORY
Please check below if you have, or have had any of the following medical conditions □ **No Past medical problems**

□ Acid reflux
□ Adverse reaction to anesthesia
□ Alzheimer's significant memory loss
□ Anemia
□ Angina or chest pain
□ Arthritis
□ Asthma
□ Atrial fibrillation or erratic heartbeat
□ Bleeding problems
□ Blood transfusion
□ Blood clot in leg(s) or lung(s)
□ Bruise easily
□ Cancer Type: _____
□ Thyroid Disease
□ Other not listed, explain: _____
□ Congestive heart failure
□ Dental disease
□ Depression
□ Diabetes
□ Emphysema
□ Epilepsy/Seizures
□ Fibromyalgia
□ Gallbladder disease
□ Gout
□ Heart disease
□ Hemophilia / Excessive bleeding
□ Hepatitis
□ High blood pressure / Hypertension
□ High cholesterol
□ Tuberculosis
□ HIV or Aids
□ Infections: _____
□ Kidney/Bladder disease
□ Leg pain
□ Lung disease
□ Osteoporosis
□ Peripheral vascular disease
□ Pneumonia
□ Psychiatric disorder
□ Rheumatoid arthritis
□ Sickle cell
□ Sleep apnea / CPAP machine
□ Stroke

FAMILY HISTORY

Please check below if Mother, Father, Siblings have had any of the following: ☐ **No family medical history to report**

	Who		Who
☐ Adverse reaction to anesthesia	_____	☐ Blood clots/Pulmonary embolism	_____
☐ Bleeding disorders	_____	☐ Cancer Type & Age	_____
☐ Depression	_____	☐ Osteoporosis	_____
☐ Diabetes	_____	☐ Rheumatoid Arthritis	_____
☐ Heart Disease (age at first event)	_____	☐ Stroke (age at first event)	_____
☐ Hypertension	_____		

SURGICAL HISTORY

Please check below if you have had any of these surgeries ☐ **No Previous Surgeries**

	Year		Year		Year
☐ Aneurysm – Abdominal	_____	☐ Colon surgery	_____	☐ Open heart surgery	_____
☐ Angioplasty / stents	_____	☐ Fistula R or L	_____	☐ Pacemaker/Defibrillator	_____
☐ Appendectomy	_____	☐ Gallbladder	_____	☐ Prostate surgery	_____
☐ Artery bypass of arm/ leg	_____	☐ Gastric bypass surgery	_____	☐ Spine surgery	_____
☐ Breast surgery	_____	☐ Heart stents	_____	☐ Tonsils	_____
☐ Caesarean section	_____	☐ Hernia surgery where	_____	☐ Total hip / knee	_____
☐ Carotid surgery	_____	☐ Hysterectomy	_____	☐ Other not listed, explain:	_____
☐ Cataract surgery	_____	☐ Nasal surgery	_____		

HOSPITALIZATIONS ☐ No Past Hospitalizations

Date: (Mo/Yr)	Reason
_____	_____
_____	_____
_____	_____

REVIEW OF SYSTEMS

- CONST fever, chills, fatigue, recent weight loss/gain, appetite problems night sweats
- EYES double vision, blurring, difficulty seeing, pain
- ENT deafness, sinusitis, hoarsness, dizziness, nose bleeds, ear pain, sore throat
- HEART chest pain, palpitations, murmur, extra beats, arm/jaw pain
- LUNG shortness of breath, wheezing, cough, bloody sputum, asthma
- INTESTINAL constipation, diarrhea, rectal bleeding, nausea, vomiting, heartburn, abdominal pain
- URINARY pain with urination, frequency, blood in urine, hesitancy, incontinence, stones
- BREAST breast masses, pain, discharge, cancer
- GYN irregular periods, hysterectomy, partial/complete
- NEURO seizures, loss of balance/coordination, weakness, memory loss, slurred speech
- ENDOCRINE excessive thirst, excessive urination, heat/cold tolerance
- SKIN persistent rashes or lesions, changes in moles, bleeding, itching
- MUSCULOSKELETAL stiffness, joint pain/deformity, muscle wasting, spine pain radiating to arms/legs
- BLOOD/LYMPHATIC anemia, bleeding tendencies, swollen lymph nodes

- PSYCH depression, anxiety, hallucinations, sleep disturbances
- ALLERGIC and IMMUNOLOGIC hives, eczema, persistent itching
- Other problems not covered above_____

To Be Filled Out By Nurse ☐ Review of symptoms negative

HEIGHT: _____ WEIGHT: _____ TEMP: _____ PULSE: _____ O2 SAT: _____

BP RIGHT ARM: _____ BP LEFT ARM: _____

FLU SHOT: _____ Date: _____

Diagnosis _____