Patient Name: _____ Date of Birth:

PLEASE ANSWER *ALL* QUESTIONS

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐NO☐YES (If yes please list medications)

MEDICATION	REACTION

Are yon allergic to: Latex ☐No ☐ Yes Iodine ☐ No ☐ Yes **Dye or contrast material** ☐No ☐Yes **Other** _____

MEDICATION

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ☐NO ☐YES (If yes please list all current medications)

MEDICATION	REASON FOR TAKING MEDICATION

Do you take Aspirin? ☐ No ☐ Yes Do you take a Blood Thinner? ☐ No ☐ Yes If yes what Blood Thinner?

SURGICAL HISTORY- Please list & note dates of your surgeries

MEDICAL HISTORY - Please list your Major Medical Problems:

FAMILY Medical History: have any family members had:

Diabetes □ No □ Yes, **if yes who?**

Family member: □ Mother □ Father □ Maternal Grandmother □ Maternal Grandfather □ Paternal Grandmother □ Paternal Grandfather □ Brother □ Sister □ No Family History

Aneurysm □ No □ Yes, if **yes who?**

Family member: □ Mother □ Father □ Maternal Grandmother □ Maternal Grandfather □ Paternal Grandmother □ Paternal Grandfather □ Brother □ Sister □ No Family History

Arthritis □ No □ Yes, if **yes who?**

Family member: □ Mother □ Father □ Maternal Grandmother □ Maternal Grandfather □ Paternal Grandmother □ Paternal Grandfather □ Brother □ Sister □ No Family History

Bleeding Disorder □ No □ Yes, if **yes who?**

Family member: □ Mother □ Father □ Maternal Grandmother □ Maternal Grandfather □ Paternal Grandmother □ Paternal Grandfather □ Brother □ Sister □ No Family History

Malignant Hyperthermia □ No □ Yes, if **yes who?**

Family member: □ Mother □ Father □ Maternal Grandmother □ Maternal Grandfather □ Paternal Grandmother □ Paternal Grandfather □ Brother □ Sister □ No Family History

Stroke □ No □ Yes, if **yes who?**

Family member: □ Mother □ Father □ Maternal Grandmother □ Maternal Grandfather □ Paternal Grandmother □ Paternal Grandfather □ Brother □ Sister □ No Family History

Heart Disease □ No □ Yes, if **yes who?**

Family member: □ Mother □ Father □ Maternal Grandmother □ Maternal Grandfather □ Paternal Grandmother □ Paternal Grandfather □ Brother □ Sister □ No Family History

Cancer □ No □ Yes, if **yes where?** □ Colon □ Kidney □ Breast □ Other:

Family member: □ Mother □ Father □ Maternal Grandmother □ Maternal Grandfather □ Paternal Grandmother □ Paternal Grandfather □ Brother □ Sister □ No Family History

None □

SOCIAL HISTORY

Occupation:

Martital Status □ Married □ Single □ Divorced □ Widowed □ Separated □ Life Partner

Smoking Status □ **Current** Every Day **Smoker** □ Current Some Day (Occasional) Smoker □ **Former Smoker**

□ **Never smoked**

Do You Drink Alcobol? □ **Never Drank**

□ **Yes, how often** □ Monthly or Less □ 2-4 times a Month □ 2-3 Times a Week □ 4 or more times a week

Do you use Recreational Drugs? □ No

□ Cocaine □ Ectasy □ Hallucinogens □ Inhalants □ Marijuana □ Other Drugs

REVIEW OF SYSTEMS: In the past 6 months have you had:

Fever: □ No □ Yes
Chills: □ No □ Yes
Changes in Vision: □ No □ Yes
Blurred Vision: □ No □ Yes
Sore Throat: □ No □ Yes
Nasal Congestion: □ No □ Yes
Nasal Discharge: □ No □ Yes
Sinus Pain: □ No □ Yes
Headaches: □ No □ Yes
Seizures: □ No □ Yes
Chest Pain: □ No □ Yes
Irregular Heartbeat: □ No □ Yes
Shortness of Breath: □ No □ Yes
Wheezing: □ No □ Yes
Nausea: □ No □ Yes
Vomiting: □ No □ Yes
Easy Bleeding: □ No □ Yes
Easy Bruising: □ No □ Yes

Constipation: □ No □ Yes
Diarrhea: □ No □ Yes
Urgency with Urination: □ No □ Yes
Frequency of Urination: □ No □ Yes
Rash: □ No □ Yes
Itching: □ No □ Yes
Tingling or Numbness: □ No □ Yes
Incoordination: □ No □ Yes
Lumps or tenderness in your breast tissue: □ No □ Yes
Bone Pain: □ No □ Yes
Back Pain: □ No □ Yes
Joint Pain: □ No □ Yes
Weight Gain: (Over 10lbs): □ No □ Yes
Weight Loss: (Over 10lbs): □ No □ Yes
Anxiety: □ No □ Yes
Depression: □ No □ Yes
Enlarged or Tender Lymph Nodes: □ No □ Yes
Sinus Allery Symptoms: □ No □ Yes

PATIENT SIGNATURE: _____ **Date:** _____