

FAMILY MEDICAL HISTORY

Please list the ages and state of health of your immediate family members (parents, siblings, children) and any health conditions for which they may have been treated:

Have you or has anyone in your family had any problems with general anesthesia? _____
Please specify: _____

Have you or has anyone in your family had any bleeding complications? _____
Please specify: _____

<i>Family Member</i>	<i>Age</i>	<i>Health Status</i>	<i>Conditions</i>
<i>Example: Mother</i>	<i>72</i>	<i>Fair</i>	<i>High blood pressure, diabetes</i>

Physician Initials: _____

Date: _____

REVIEW OF SYSTEMS (Please circle any of the following symptoms if you have experienced them in the last 6 months)

- General: Fever, chills, recent weight loss, night sweats
- Skin: Excessive itching, dryness
- Head: Headache, seizures, dizziness, fainting spells
- Ears: Pain, loss of hearing, spinning sensation
- Nose: Frequent bleeding, sinusitis, snoring, postnasal drip, drainage
- Mouth: Painful teeth, painful or bleeding gums, tongue, taste abnormalities, hoarseness, changes in voice
- Breasts: Pain, lumps, infection, drainage
- Lungs: Shortness of breath, pain with breathing, frequent cough, whitish phlegm, yellowish phlegm, wheezing, difficulty breathing at night, snoring
- Heart: Chest pain, palpitations, murmur, leg/foot/ankle swelling
- Intestinal: Heartburn, ulcers, hepatitis, jaundice, gallstones, nausea, vomiting, diarrhea, constipation, change in bowel habits, blood in stool, hernia, colon polyps, diverticulitis
- Urinary: Frequency, urgency, hesitancy, incontinence, pain with urination, frequent infections, pain, change in sexual function/desire, sexually transmitted disease
- Extremities: Pain, stiffness, swelling, loss of range of motion
- Back/Neck: Pain, stiffness, limited movement, cracking/popping noise
- Blood: Anemia, bleeding tendency, history of blood transfusion, bruise easily
- Endocrine: Change in appetite, heat or cold intolerance, excessive thirst, nervousness
- Neurologic: Tremor, seizures, paralysis, loss of sensation, numbness, weakness

Physician Initials: _____

Date: _____