PATIENT NAME: ____ **DATE:**___/___/________

REFERRED BY: (IF APPLICABLE) ____

SOCIAL HISTORY: ❑**NO CHANGES TO SOCIAL HISTORY**

IF FEMALE, ARE YOU PREGNANT, THINK YOU MAY BE PREGNANT, OR ARE NURSING?:

❑NO ❑YES, I AM:____

DO YOU SMOKE?: ❑NO ❑YES HOW MANY PER DAY?: ____________

DRINK ALCOHOL?: ❑NO ❑YES,HOW MUCH PER DAY?____________

DO YOU USE ANY ILLICIT DRUGS: ❑NO ❑YES (PLEASE LIST): ____

DO YOU USE TANNING BEDS?: ❑NO ❑YES, HOW FREQUENTLY? _______________

DO YOU USE SUN SCREEN?: ❑NO ❑YES

DO YOU PREMEDICATE FOR PROCEDURES? ❑**NO CHANGES TO BLOOD THINNERS/ASPRIN PRODUCTS**

❑NO

❑YES (PLEASE LIST THE MEDICATION YOU TAKE): ____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?: ❑**NO CHANGES TO ALLERGIES**

❑LATEX ❑LIDOCANE ❑BEE STINGS ❑VACCINES ❑EGGS ❑PEANUTS ❑MILK ❑ADHESIVE TAPE

ARE YOU ALLERGIC TO ANY MEDICATIONS?: ❑NO ❑YES, PLEASE LIST BELOW

1.________________________ 2.________________________ 3.________________________

4.________________________ 5.________________________ 6.________________________

____

PAST MEDICAL HISTORY. HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?: (PLEASE CHECK ANY THAT APPLY) **❑NO CHANGES TO PAST MEDICAL HISTORY**

❑CATARACTS ❑GLAUCOMA ❑DEPRESSION ❑DIABETES

❑THYROID DISEASE ❑HIGH CHOLESTEROL ❑HIGH BLOOD PRESSURE ❑PULMONARY EMBOLISM

❑DEEP VEIN THROMBOSIS ❑HEART ATTACK ❑HEART FAILURE ❑HEART MURMOR

❑ARTIFICAL HEART VALVE ❑RHEUMATIC FEVER ❑STROKE ❑SEIZURES/EPILEPSY

❑MENINGITIS ❑ASTHMA ❑EMPHYSEMA ❑BRONCHITIS

❑TUBERCULOSIS ❑PNEUMONIA ❑LIVER DISEASE ❑PANCREATITIS

❑GOUT ❑JOINT REPLACEMENT ❑HIV INFECTION/AIDS ❑HEPATITIS B OR C

OTHER: ____

____

REVIEW OF SYSTEMS. DO YOU HAVE?: (PLEASE CHECK ANY THAT APPLY) **❑NO CHANGES TO MY REVIEW OF SYSTEMS**

❑WEIGHT CHANGE ❑FATIGUE/ENERGY LOSS ❑FEVERS ❑ANEMIA

❑NIGHT SWEATS ❑CHANGES IN NAILS ❑HAIR LOSS ❑FREQUENT INFECTIONS

❑SWOLLEN GLANDS ❑RUNNY NOSE ❑BLURRY VISION ❑BLINDNESS

❑LIGHT SENSITIVITY ❑RASH ❑ITCHING ❑FLUSHING

❑COLOR CHANGES ❑SINUS PROBLEMS ❑SORE THROAT ❑CHANGES IN VOICE

❑TROUBLE SWALLOWING ❑ABDOMINAL PAIN ❑LOSS OF APPETITE ❑MURMUR

❑NAUSEA OR VOMITING ❑CONSTIPATION ❑DIARRHEA ❑BLOATING

❑BLOOD IN STOOLS ❑CHEST PAIN ❑IRREGULAR HEARTBEAT

❑SWELLING IN FEET ❑SHORTNESS OF BREATH ❑WHEEZING ❑COUGH

❑LOSS OF BLADDER CONTROL ❑FREQUENT URINATION ❑MENSTRUAL PROBLEMS

❑BLEED OR BRUISE EASILY ❑BLOOD CLOTS ❑MUSCLE WEAKNESS ❑MOOD CHANGES

❑MUSCLE PAIN ❑ARTHRISIS OR JOINT PAIN ❑BACK OR NECK PAIN

❑DIZZINESS ❑FAINTING ❑NUMBNESS ❑TINGLING

❑DEPRESSION ❑ANXIETY OR NERVOUSNESS ❑HEARTBURN OR ULCERS

❑HEAT OR COLD INTOLERANCE ❑MISCARRIAGES ❑HEADACHES OR MIGRANES

PATIENT SIGNATURE: ____ **DATE:** _____/_____/______

REVIEWED BY DR POLISKY: ______________________________________ **DATE:** _____/_____/______