

Date: \_\_\_\_\_

## REVIEW OF PATIENT MEDICAL HISTORY QUESTIONNAIRE

**Instructions:** Please complete this questionnaire to the best of your ability. Please print your answers.

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: \_\_\_\_\_ Insurance Type: \_\_\_\_\_ Do you use Avera Chart?  Yes  No

Referring Doctor: \_\_\_\_\_ From City, State: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ From City, State: \_\_\_\_\_

Should any other doctor receive a copy of our doctor's note from today? (If yes, whom?) \_\_\_\_\_

### MEDICATIONS

Please list all of your medications (*including anything over-the-counter*)

Medication/Vitamin/Supplement Name	Dosage	How Often

### ALLERGIES

Please list any allergies (*including medications, iodine, anesthesia, latex, tape, etc.*)

Allergic to:	Reaction (hives, swelling, difficulty breathing, etc.)

## HOSPITALIZATIONS

Please list any hospitalizations in the last 10 years.

Date(s)	Hospital	Condition Treated/Reason for Admission

**Instructions:** Please complete this portion of the questionnaire by marking all that apply to you.

## MEDICAL HISTORY

**Head, Ears, Eyes, Nose, and Throat:**  *None of these apply*

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cataracts                   | <input type="checkbox"/> Laryngomalacia           | <input type="checkbox"/> Seasonal allergies    |
| <input type="checkbox"/> Cleft lip/palate            | <input type="checkbox"/> Macular degeneration     | <input type="checkbox"/> Recurrent tonsillitis |
| <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Recurrent ear infections | <input type="checkbox"/> Tracheomalacia        |
| <input type="checkbox"/> History of head/neck cancer | <input type="checkbox"/> Recurrent sinusitis      | <input type="checkbox"/> Other: _____          |

**Endocrine:**  *None of these apply*

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Adrenal disease      | <input type="checkbox"/> Graves' disease     | <input type="checkbox"/> Pre-Diabetes         |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Hyperparathyroidism | <input type="checkbox"/> Vitamin D deficiency |
| <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Hyperthyroidism     | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Goiter               | <input type="checkbox"/> Hypothyroidism      | <input type="checkbox"/> Other: _____         |

**Respiratory:**  *None of these apply*

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> Allergies/hay fever | <input type="checkbox"/> COPD        | <input type="checkbox"/> Pulmonary embolism |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> C-PAP/BiPap | <input type="checkbox"/> Sleep apnea        |
| <input type="checkbox"/> Chronic bronchitis  | <input type="checkbox"/> Pneumonia   | <input type="checkbox"/> Other: _____       |

**Cardiovascular:**  *None of these apply*

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Abdominal aortic aneurysm | <input type="checkbox"/> Deep venous thrombosis           | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Angina                    | <input type="checkbox"/> Heart failure                    | <input type="checkbox"/> Phlebitis                   |
| <input type="checkbox"/> Atrial fibrillation       | <input type="checkbox"/> Heart murmur                     | <input type="checkbox"/> Pulmonary hypertension      |
| <input type="checkbox"/> Cardiac arrest            | <input type="checkbox"/> Heart valve disease              | <input type="checkbox"/> QTC prolongation            |
| <input type="checkbox"/> Cardiac arrhythmias       | <input type="checkbox"/> Hyperlipidemia/high cholesterol  | <input type="checkbox"/> Rheumatic heart disease     |
| <input type="checkbox"/> Cardiomyopathy            | <input type="checkbox"/> Hypertension/high blood pressure | <input type="checkbox"/> Syncope (fainting)          |
| <input type="checkbox"/> Carotid stenosis          | <input type="checkbox"/> Myocardial infarction            | <input type="checkbox"/> Varicosities                |
| <input type="checkbox"/> Congenital heart disease  | <input type="checkbox"/> Palpitations                     | <input type="checkbox"/> Venous Insufficiency        |
| <input type="checkbox"/> Coronary artery disease   | <input type="checkbox"/> Peripheral edema                 | <input type="checkbox"/> Other: _____                |

**Gastrointestinal (continued on next page):**  *None of these apply*

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Celiac disease       | <input type="checkbox"/> Colon polyp      | <input type="checkbox"/> Hemorrhoids              |
| <input type="checkbox"/> Chronic constipation | <input type="checkbox"/> Crohn's disease  | <input type="checkbox"/> Hepatitis                |
| <input type="checkbox"/> Chronic diarrhea     | <input type="checkbox"/> Diverticulitis   | <input type="checkbox"/> Hiatal hernia            |
| <input type="checkbox"/> Cirrhosis            | <input type="checkbox"/> Diverticulosis   | <input type="checkbox"/> Inguinal hernia (groin)  |
| <input type="checkbox"/> Colitis              | <input type="checkbox"/> Gallstones       | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> Colitis – ulcerative | <input type="checkbox"/> GERD/acid reflux | <input type="checkbox"/> Jaundice                 |

**Gastrointestinal (continued):**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Peptic ulcer disease            | <input type="checkbox"/> Ventral hernia |
| <input type="checkbox"/> Pancreatitis  | <input type="checkbox"/> Umbilical hernia (belly button) | <input type="checkbox"/> Other: _____   |

**Genitourinary:**  *None of these apply*

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> BPH/Benign Prostatic Hyperplasia | <input type="checkbox"/> Kidney dialysis       | <input type="checkbox"/> Past UTI/urinary tract infection |
| <input type="checkbox"/> Decreased libido/sex drive       | <input type="checkbox"/> Kidney disease        | <input type="checkbox"/> Prostate problems                |
| <input type="checkbox"/> Erectile dysfunction             | <input type="checkbox"/> Kidney failure        | <input type="checkbox"/> Testicular problems              |
| <input type="checkbox"/> Hydronephrosis                   | <input type="checkbox"/> Kidney stones         | <input type="checkbox"/> Undescended testicle             |
| <input type="checkbox"/> Hypogonadism                     | <input type="checkbox"/> Overactive bladder    | <input type="checkbox"/> Urinary incontinence             |
| <input type="checkbox"/> Interstitial cystitis            | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Other: _____                     |

**Sexually Transmitted Infection:**  *None of these apply*

- |                                    |  |   |
|------------------------------------|--|---|
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Herpes genitalis          | <input type="checkbox"/> Syphilis       |
| <input type="checkbox"/> Condyloma | <input type="checkbox"/> HIV                       | <input type="checkbox"/> Trichomoniasis |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> HPV/Human papilloma virus | <input type="checkbox"/> Other: _____   |

**Breasts:**  *None of these apply*

- |                                       |   |                                       |
|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Benign cyst  | <input type="checkbox"/> Fibrocystic breast disease | <input type="checkbox"/> Mastitis     |
| <input type="checkbox"/> Fibroadenoma | <input type="checkbox"/> Lump or mass               | <input type="checkbox"/> Other: _____ |

**Gynecologic (FEMALE ONLY):**  *None of these apply*

- |  |  |  |
|--|--|--|
| Age at first period: _____                   | Age at menopause: _____  | Dates of last period: _____                          |
| Pregnancy History:                           | # of Pregnancies: _____  | # of Births: _____                                   |
| <input type="checkbox"/> Abnormal pap smear  | <input type="checkbox"/> Lichen planus/sclerosis               | <input type="checkbox"/> Recurrent vaginal infection |
| <input type="checkbox"/> Candida albican     | <input type="checkbox"/> Overactive bladder                    | <input type="checkbox"/> Uterine anomaly             |
| <input type="checkbox"/> Cervical dysplasia  | <input type="checkbox"/> Pelvic relaxation                     | <input type="checkbox"/> Vulvar dysplasia            |
| <input type="checkbox"/> Chronic pelvic pain | <input type="checkbox"/> PID/Pelvic inflammatory disease       | <input type="checkbox"/> Vulvar vestibulitis         |
| <input type="checkbox"/> Endometriosis       | <input type="checkbox"/> PMDD/Pre-menstrual dysphoric disorder | <input type="checkbox"/> Fibroids                    |
| <input type="checkbox"/> Infertility         | <input type="checkbox"/> PCOS/Polycystic ovarian syndrome      | <input type="checkbox"/> Other: _____                |

**Hematology:**  *None of these apply*

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Lupus anticoagulant     | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Antithrombin deficiency   | <input type="checkbox"/> MTHFR                   | <input type="checkbox"/> Thrombocytopenia    |
| <input type="checkbox"/> Chronic anticoagulation   | <input type="checkbox"/> Protein C deficiency    | <input type="checkbox"/> Thrombocytosis      |
| <input type="checkbox"/> Factor V Leiden           | <input type="checkbox"/> Protein S deficiency    | <input type="checkbox"/> Transfusion         |
| <input type="checkbox"/> Hemolytic Uremia Syndrome | <input type="checkbox"/> Prothrombin II mutation | <input type="checkbox"/> Other: _____        |

**Lymphatic:**  *None of these apply*

- |  |                                     |                                       |
|--|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Lymphadenopathy | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Lymphangitis |
| <input type="checkbox"/> Lymphadenitis   |                                     | <input type="checkbox"/> Other: _____ |

**Musculoskeletal:**  *None of these apply*

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Osteoporosis/weak, brittle bones |
| <input type="checkbox"/> Carpal tunnel                  | <input type="checkbox"/> Fractures            | <input type="checkbox"/> Rickets                          |
| <input type="checkbox"/> Cervical disc disease          | <input type="checkbox"/> Gout                 | <input type="checkbox"/> Rotator cuff tear                |
| <input type="checkbox"/> Chronic back pain              | <input type="checkbox"/> Instability          | <input type="checkbox"/> Scoliosis                        |
| <input type="checkbox"/> Contractures                   | <input type="checkbox"/> Lumbar disc disease  | <input type="checkbox"/> Spinal stenosis                  |
| <input type="checkbox"/> DJD/Degenerative joint disease | <input type="checkbox"/> Osteopenia/bone loss | <input type="checkbox"/> Other: _____                     |

**Rheumatologic:**  *None of these apply*

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Ankylosing spondylitis          | <input type="checkbox"/> Psoriatic arthritis  | <input type="checkbox"/> Scleroderma        |
| <input type="checkbox"/> Lupus                           | <input type="checkbox"/> Raynaud's disease    | <input type="checkbox"/> Sjogren's syndrome |
| <input type="checkbox"/> Mixed connective tissue disease | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Other: _____       |

**Cancer:**  *None of these apply*

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Blood cancer            | <input type="checkbox"/> Genitourinary cancer   | <input type="checkbox"/> Pancreatic cancer |
| <input type="checkbox"/> Brain cancer            | <input type="checkbox"/> Kidney cancer          | <input type="checkbox"/> Prostate cancer   |
| <input type="checkbox"/> Breast cancer           | <input type="checkbox"/> Leukemia               | <input type="checkbox"/> Skin cancer       |
| <input type="checkbox"/> Cervical cancer         | <input type="checkbox"/> Liver cancer           | <input type="checkbox"/> Stomach cancer    |
| <input type="checkbox"/> Colorectal cancer       | <input type="checkbox"/> Lung cancer            | <input type="checkbox"/> Testicular cancer |
| <input type="checkbox"/> Endocrine cancer        | <input type="checkbox"/> Lymphoma               | <input type="checkbox"/> Thyroid cancer    |
| <input type="checkbox"/> Esophageal cancer       | <input type="checkbox"/> Musculoskeletal cancer | <input type="checkbox"/> Uterine cancer    |
| <input type="checkbox"/> Eye cancer              | <input type="checkbox"/> Neurologic cancer      | <input type="checkbox"/> Vaginal cancer    |
| <input type="checkbox"/> Fallopian tube cancer   | <input type="checkbox"/> Oral cancer            | <input type="checkbox"/> Vulvar cancer     |
| <input type="checkbox"/> Gastrointestinal cancer | <input type="checkbox"/> Ovarian cancer         | <input type="checkbox"/> Other: _____      |

**Infectious Disease:**  *None of these apply*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> AIDS                         | <input type="checkbox"/> Measles              | <input type="checkbox"/> Shingles                          |
| <input type="checkbox"/> BK Virus                     | <input type="checkbox"/> Meningitis           | <input type="checkbox"/> Syphilis                          |
| <input type="checkbox"/> Chickenpox                   | <input type="checkbox"/> MRSA                 | <input type="checkbox"/> Toxoplasmosis                     |
| <input type="checkbox"/> C-Diff/Clostridium Difficile | <input type="checkbox"/> Mumps                | <input type="checkbox"/> Tuberculosis                      |
| <input type="checkbox"/> Cytomegalovirus              | <input type="checkbox"/> Polio                | <input type="checkbox"/> Vancomycin resistant enterococcus |
| <input type="checkbox"/> Epstein-Barr virus           | <input type="checkbox"/> Positive PPD/TB test | <input type="checkbox"/> West Nile Virus                   |
| <input type="checkbox"/> Hepatitis                    | <input type="checkbox"/> Rheumatic fever      | <input type="checkbox"/> Other: _____                      |
| <input type="checkbox"/> HIV                          | <input type="checkbox"/> Rubella              |  |

**Integumentary:**  *None of these apply*

- |                                    |  |  |
|------------------------------------|--|--|
| <input type="checkbox"/> Acne      | <input type="checkbox"/> Problems with healing | <input type="checkbox"/> Sunburn w/ blistering |
| <input type="checkbox"/> Eczema    | <input type="checkbox"/> Keloids               | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> Psoriasis |  |  |

**Neurologic:**  *None of these apply*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Cerebral aneurysm      | <input type="checkbox"/> Hydrocephalus          | <input type="checkbox"/> Seizures                      |
| <input type="checkbox"/> Cerebral palsy         | <input type="checkbox"/> Insomnia               | <input type="checkbox"/> Sensory processing disorder   |
| <input type="checkbox"/> Coma                   | <input type="checkbox"/> Intra-cranial bleeding | <input type="checkbox"/> Speech/language disorder      |
| <input type="checkbox"/> Concussion             | <input type="checkbox"/> Mental retardation     | <input type="checkbox"/> Stroke                        |
| <input type="checkbox"/> Dementia               | <input type="checkbox"/> Multiple sclerosis     | <input type="checkbox"/> TBI/Traumatic brain injury    |
| <input type="checkbox"/> Developmental delay    | <input type="checkbox"/> Narcolepsy             | <input type="checkbox"/> TIA/Transient Ischemic Attack |
| <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Parkinson's disease    | <input type="checkbox"/> Tremors                       |
| <input type="checkbox"/> Fetal alcohol syndrome | <input type="checkbox"/> Peripheral neuropathy  | <input type="checkbox"/> Trigeminal neuralgia          |
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Restless leg syndrome  | <input type="checkbox"/> Other: _____                  |

**Psychiatric (continued on next page):**  *None of these apply*

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Addiction                                     | <input type="checkbox"/> Asperger's disorder | <input type="checkbox"/> Cyclothymic        |
| <input type="checkbox"/> ADD/Attention deficit disorder                | <input type="checkbox"/> Autism              | <input type="checkbox"/> Depression         |
| <input type="checkbox"/> ADHD/Attention deficit hyperactivity disorder | <input type="checkbox"/> Behavior problems   | <input type="checkbox"/> Dysthymic          |
| <input type="checkbox"/> Anorexia nervosa                              | <input type="checkbox"/> Bipolar disorder    | <input type="checkbox"/> ECT treatment      |
| <input type="checkbox"/> Anxiety                                       | <input type="checkbox"/> Bulimia             | <input type="checkbox"/> Homicidal ideation |

**Psychiatric (continued):**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Learning problems                 | <input type="checkbox"/> Pervasive development disorder      | <input type="checkbox"/> Schizophrenia                  |
| <input type="checkbox"/> Mood disorders                    | <input type="checkbox"/> Psychosis                           | <input type="checkbox"/> Social anxiety                 |
| <input type="checkbox"/> OCD/Obsessive Compulsive Disorder | <input type="checkbox"/> PTSD/Post Traumatic Stress Disorder | <input type="checkbox"/> Suicidal thoughts or ideations |
| <input type="checkbox"/> Panic disorder                    | <input type="checkbox"/> Schizoaffective disorder            | <input type="checkbox"/> Other: _____                   |

**Genetic/Metabolic:**  None of these apply

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Birth defects        | <input type="checkbox"/> Cystic fibrosis    | <input type="checkbox"/> Obesity      |
| <input type="checkbox"/> Chromosomal disorder | <input type="checkbox"/> Down syndrome      | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Congenital deformity | <input type="checkbox"/> Metabolic syndrome |                                       |

**Events:**  None of these apply

- |                                       |  |   |
|---------------------------------------|--|---|
| <input type="checkbox"/> Anaphylaxis  | <input type="checkbox"/> Gunshot wound | <input type="checkbox"/> Motor vehicle accident |
| <input type="checkbox"/> Other: _____ |  |   |

**Disabilities:**  None of these apply

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> Cognitive/learning disability | <input type="checkbox"/> Hemiparesis | <input type="checkbox"/> Quadriplegia              |
| <input type="checkbox"/> Hearing impairment/deficit    | <input type="checkbox"/> Paraplegia  | <input type="checkbox"/> Vision impairment/deficit |
| <input type="checkbox"/> Other: _____                  |                                      |  |

**SURGICAL HISTORY**

**Head, Ears, Eyes, Nose, and Throat:**  None of these apply

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Adenoidectomy (adenoids) | <input type="checkbox"/> Dental surgery | <input type="checkbox"/> Lasik eye surgery       |
| <input type="checkbox"/> Cataract extraction      | <input type="checkbox"/> Ear surgery    | <input type="checkbox"/> Tonsillectomy (tonsils) |
| <input type="checkbox"/> Cleft lip/palate repair  | <input type="checkbox"/> Laryngectomy   | <input type="checkbox"/> Other: _____            |

**Endocrine:**  None of these apply

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Parathyroidectomy | <input type="checkbox"/> Thyroid surgery | <input type="checkbox"/> Other: _____ |
|--|--|---------------------------------------|

**Respiratory:**  None of these apply

- |                                       |                                    |                                       |
|---------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Lobectomy | <input type="checkbox"/> Other: _____ |
|---------------------------------------|------------------------------------|---------------------------------------|

**Cardiovascular:**  None of these apply

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Ablation                          | <input type="checkbox"/> Carotid endarterectomy                     | <input type="checkbox"/> Pacemaker         |
| <input type="checkbox"/> Angiogram                         | <input type="checkbox"/> Congenital defect repair                   | <input type="checkbox"/> Valve replacement |
| <input type="checkbox"/> Angioplasty                       | <input type="checkbox"/> Coronary stent                             | <input type="checkbox"/> Venous surgery    |
| <input type="checkbox"/> CABG/Coronary Artery Bypass Graft | <input type="checkbox"/> Heart transplant                           | <input type="checkbox"/> Other: _____      |
| <input type="checkbox"/> Cardioversion                     | <input type="checkbox"/> ICD/Implantable Cardioverter Defibrillator |  |

**Gastrointestinal:**  None of these apply

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Appendectomy (appendix)       | <input type="checkbox"/> Exploratory laparotomy    | <input type="checkbox"/> Weight Loss Surgery      |
| <input type="checkbox"/> Cholecystectomy (gallbladder) | <input type="checkbox"/> Hemorrhoidectomy          | <input type="checkbox"/> Lap Band                 |
| <input type="checkbox"/> Colectomy (colon resection)   | <input type="checkbox"/> Hernia repair: _____      | <input type="checkbox"/> Roux-en-Y Gastric Bypass |
| <input type="checkbox"/> Colonoscopy                   | <input type="checkbox"/> Pancreatectomy (pancreas) | <input type="checkbox"/> Sleeve Gastrectomy       |
| <input type="checkbox"/> Endoscopy/EGD                 | <input type="checkbox"/> Splenectomy (spleen)      | <input type="checkbox"/> Other: _____             |

**Genitourinary:**  None of these apply

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Bladder surgery         | <input type="checkbox"/> Kidney transplant | <input type="checkbox"/> TURP/Transurethral Resection of Prostate |
| <input type="checkbox"/> Bulking agent           | <input type="checkbox"/> Lithotripsy       | <input type="checkbox"/> Vasectomy                                |
| <input type="checkbox"/> Cystoscopy              | <input type="checkbox"/> Nephrectomy       | <input type="checkbox"/> Other: _____                             |
| <input type="checkbox"/> Kidney stone extraction | <input type="checkbox"/> Prostatectomy     |   |

**Musculoskeletal:**  None of these apply

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Arthroscopy           | <input type="checkbox"/> Fracture(s) repair | <input type="checkbox"/> Rotator cuff repair |
| <input type="checkbox"/> Carpal tunnel release | <input type="checkbox"/> Joint replacement  | <input type="checkbox"/> Other: _____        |

**Integumentary:**  None of these apply

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Skin cancer removal | <input type="checkbox"/> Plastic surgery | <input type="checkbox"/> Other: _____ |
|--|--|---------------------------------------|

**Neurologic:**  None of these apply

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Craniotomy     | <input type="checkbox"/> VP shunt placement | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Spinal surgery | <input type="checkbox"/> VP shunt revision  |                                       |

**Breasts:**  None of these apply

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Breast augmentation | <input type="checkbox"/> Breast reduction | <input type="checkbox"/> Mastectomy: _____ |
| <input type="checkbox"/> Breast biopsy       | <input type="checkbox"/> Lumpectomy       | <input type="checkbox"/> Other: _____      |

**Gynecologic (FEMALE ONLY):**  None of these apply

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Ablation                     | <input type="checkbox"/> Fulguration endometriosis   | <input type="checkbox"/> Oophorectomy           |
| <input type="checkbox"/> Cervical conization/LEEP     | <input type="checkbox"/> Hysterectomy: <input type="checkbox"/> Total <input type="checkbox"/> Partial | <input type="checkbox"/> Ovarian surgery        |
| <input type="checkbox"/> Cervical surgery             | Approach:  | <input type="checkbox"/> Pelvic support surgery |
| <input type="checkbox"/> Cesarean delivery/C-section  | <input type="checkbox"/> Abdominal <input type="checkbox"/> Vaginal                                    | <input type="checkbox"/> Tubal ligation         |
| <input type="checkbox"/> D & C (dilation & curettage) | <input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open                                    | <input type="checkbox"/> Other: _____           |

**SOCIAL HISTORY**

**Tobacco Use:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Current every day smoker  | <input type="checkbox"/> Smokeless tobacco user | <input type="checkbox"/> Never smoker           |
| <input type="checkbox"/> Current occasional smoker | <input type="checkbox"/> Former smoker          | <input type="checkbox"/> Unknown if ever smoked |

**Alcohol Use:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> None                  | <input type="checkbox"/> 2+ drinks per day   | <input type="checkbox"/> 1-2 drinks per month |
| <input type="checkbox"/> 0 to 2 drinks per day | <input type="checkbox"/> 1-2 drinks per week | <input type="checkbox"/> Other: _____         |

**Substance/Drug Use:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> None                | <input type="checkbox"/> Hallucinogens   | <input type="checkbox"/> Opiates                 |
| <input type="checkbox"/> Amphetamines        | <input type="checkbox"/> Inhalants       | <input type="checkbox"/> Painkillers             |
| <input type="checkbox"/> Club/designer drugs | <input type="checkbox"/> Injection drugs | <input type="checkbox"/> Tranquilizers/sedatives |
| <input type="checkbox"/> Cocaine/crack       | <input type="checkbox"/> Marijuana       | <input type="checkbox"/> Other: _____            |

**FAMILY MEDICAL HISTORY**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Acute myocardial infarction    | <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Obesity               |
| <input type="checkbox"/> Adverse reaction to anesthesia | <input type="checkbox"/> Drug abuse                       | <input type="checkbox"/> Other blood disorders |
| <input type="checkbox"/> Alcohol abuse                  | <input type="checkbox"/> Eczema                           | <input type="checkbox"/> Ovarian cancer        |
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Gastric cancer                   | <input type="checkbox"/> Pancreatic cancer     |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Genetic disorder                 | <input type="checkbox"/> Prostate cancer       |
| <input type="checkbox"/> Atherosclerosis                | <input type="checkbox"/> Hyperlipidemia/high cholesterol  | <input type="checkbox"/> Rheumatoid arthritis  |
| <input type="checkbox"/> Autoimmune disorder            | <input type="checkbox"/> Hypertension/high blood pressure | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Breast cancer                  | <input type="checkbox"/> Kidney disease                   | <input type="checkbox"/> Skin cancer           |
| <input type="checkbox"/> Cerebrovascular accident       | <input type="checkbox"/> Learning disability              | <input type="checkbox"/> Thyroid disease       |
| <input type="checkbox"/> Colon cancer                   | <input type="checkbox"/> Liver disease                    | <input type="checkbox"/> Tobacco abuse         |
| <input type="checkbox"/> Congenital anomaly             | <input type="checkbox"/> Lung cancer                      | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Congestive heart failure       | <input type="checkbox"/> Malignant hyperthermia           | <input type="checkbox"/> No history available  |
| <input type="checkbox"/> Coronary artery disease        | <input type="checkbox"/> Malignant neoplasm of kidney     | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> Dementia                       | <input type="checkbox"/> Malignant neoplasm of uterus     | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> Depression                     | <input type="checkbox"/> Mental disorder                  | <input type="checkbox"/> None of these apply   |