



Please fill out form completely – Do not leave any spaces blank – If it does not apply, please write in "N/A"

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Allergies (Any meds you cannot take?) \_\_\_\_\_

Date of injury/first symptom \_\_\_\_/\_\_\_\_/\_\_\_\_ Is condition/injury work related? Yes \_\_\_\_ No \_\_\_\_

Do you have a hospital preference? (circle one) Athens Regional St. Mary's No Preference

List previous surgeries and dates if known \_\_\_\_\_

Have you or any family member ever had complications related to anesthesia including high fever? \_\_\_\_\_

List all current medications (include aspirin, birth control, vitamins) \_\_\_\_\_

Past Medical History: Have you ever had the following...

	YES	NO		YES	NO		YES	NO
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, type _____			Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Bowel/stomach disorders	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Keloids/excessive scaring	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Cough > 3 wks	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

Family History: Has any blood relative had the following...  Adopted or Unknown

	YES	NO		YES	NO		YES	NO
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, type _____			Other _____		

Reviews of Systems: Do you have or have you had in the last year...

	YES	NO		YES	NO		YES	NO
Weight change	<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles/feet	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>	Joint or muscle problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Chronic diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	swollen lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Rapid heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Urinary problems	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

Do you smoke/use tobacco products?  Yes  No Packs/Day \_\_\_\_ Other \_\_\_\_\_

Do you drink alcohol?  Yes  No Drinks/Day \_\_\_\_

Is there any chance that you are pregnant?  Yes  No

I verify that the above information is true and accurate to the best of my knowledge.

X \_\_\_\_\_  
 Signature of Patient/Responsible Party

\_\_\_\_\_  
 Date