Patient Evaluation Form

Patient Name_____

Date of Birth_____Height_____Weight_____

(If you need more space for any part of this form, please ask for additional paper.) If you have a pre-prepared list of medications, etc., please attach them to the back of this form. Thank you.

Why are you coming to see us today:_____

When did this problem begin: _____

Please list previous surgeries or hospitalizations along with the date below:

Year	Surgery or hospitalization	Complications or Difficulties

Please list any medications, vitamins, herbs, or non-prescription medication you are using.

Medication	Dose	Times/day

Please list any allergies that you have and the type of reaction you get

Allergies	Reaction

Do you take any blood thinners like Coumadin or aspirin Yes / No

Social History (Please Circle):

Do you smoke or Chew Tobacco Yes / No How much _____

Do you drink Alcohol Yes / No How much _____

Do you take Recreational Drugs Yes / No How much _____

Do you live alone Yes / No With whom _____

Family & Past Medical History (Please check if applicable):

Heart Disease	Self	Family	Comments	Diabetes	Self	Familiity	Comments
Heart Murmur				Cancer - Type			
High Blood Pressure				Kidney Disease			
Blood Clots				Epilepsy/Convulsion			
Stroke				AIDS or HIV +			
Bleeding Disorder				Thyroid Disease			
Anemia				Tuberculosis			
Hepatitis				Depression			

Do you have now or have you had within the past year (Please circle):

Weight Change	Yes / No	Rapid Heart Beat	Yes / No
Dryes eyes	Yes / No	Chest pain	Yes / No
Shortness of Breath	Yes / No	High Cholesterol	Yes / No
Seizures	Yes / No	Swollen Feet/Ankles	Yes / No

This section for Women Only

Birth Control Type	Yes / No _____
Number of Pregnancies / Births	_____ / ____
Last Pap Smear	
Last Mammogram	

This section for Men Only

Prostate Screening	Yes / No
Testicular Exam	Yes / No

Patient Signature _____