

Patient Evaluation Form

Patient Name: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **Age:** _____
 (If you need more space 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

Please list any medications you are taking, including non-prescription drugs, vitamins and herbals below:

Please list **any** allergies below (this includes any drug allergies):

Medication	Dose	Times /day

Allergies

Social History (Please Circle):

Do you smoke/chew tobacco No Yes How much: Are you employed No Yes
 Do you drink alcohol No Yes How much: Do you live alone No Yes
 Do you take recreational drugs No Yes What: If no, who do you live with:

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

	Self		Family	Comments		Self		Family	Comments
Heart Disease					Diabetes				
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 No Yes Swollen feet/ankles No Yes Seizures No Yes
 Dry eyes No Yes Chest pain No Yes Rapid heart beat No Yes
 Shortness of breath No Yes High cholesterol No Yes

This section for women only: **Answer**

Birth Control	
Number of pregnancies/births	/
Last PAP smear	
Last mammogram	

This section for men only: **Answer**

Prostate screening	Yes	No
Testicular exam	Yes	No

When did you receive your last tetanus shot? _____

Patient's signature: _____ Date: _____

Physician's signature: _____ Date: _____