Family History

Patient Name _____

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	☐	☐		
Grandfather (mom's)	☐	☐		
Grandmother (dad's)	☐	☐		
Grandfather (dad's)	☐	☐		
Father	☐	☐		
Mother	☐	☐		
Sister/Brother	☐	☐		
Sister/Brother	☐	☐		
Sister/Brother	☐	☐		
Sister/Brother	☐	☐		

Past Medical History

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia? No ☐ Yes ☐

Have any problems with anesthesia? No ☐ Yes ☐ Describe: _____

Review of Systems - Are you currently having or have you had problems with your

	Circle		**Describe all Yes**
Eyes	No	Yes	
Ears, Nose, Throat	No	Yes	
Lungs, Breathing	No	Yes	
Digestion	No	Yes	
Bowel movement	No	Yes	
Bladder problem	No	Yes	
Diabetes	No	Yes	
Heart	No	Yes	
High blood pressure	No	Yes	
Bleeding problems	No	Yes	
Balance problems	No	Yes	
Numbness / tingling	No	Yes	
Blackout / fainting	No	Yes	
Psychological problems	No	Yes	
AIDS	No	Yes	
Cancer	No	Yes	
Arthritis	No	Yes	
Polio	No	Yes	
TB	No	Yes	
Epilepsy	No	Yes	
Other			

Patient Signature: _____ Date: _____