

16. Past **medical conditions** that you have been **diagnosed** with (i.e. hypertension, high cholesterol, diabetes, stroke, etc): _____

17. Past **surgical history** with **dates** (i.e. spinal fusion, hip replacement, hernia repair): _____

Social History

Occupation: _____

Smoking/tobacco use: current former never **Type:** _____ **How often:** _____

Alcohol use: current former never **How often:** _____

History of substance abuse (including alcohol)?: yes no

Medications

Name	Strength	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you taking any blood thinners (i.e. Plavix/Clopidogrel, Coumadin/Warfarin, Effient/Prasugrel): yes no

If yes, which medication?: _____

Allergies
(including medications/food)

Name	Reaction
_____	_____
_____	_____
_____	_____

Are you allergic to crab, shellfish, iodine or contrast dye? yes no

Review of Systems *(check all that apply)*

Constitutional

- fever
- general fatigue

Respiratory

- shortness of breath

Cardiology

- chest pain
- palpitations
- dizziness

Dermatology

- skin rash

Gastrointestinal

- heartburn
- constipation
- nausea
- vomiting
- abdominal pain
- diarrhea
- liver issues

Genitourinary

- sexual dysfunction
- kidney stones

Musculoskeletal

- limited range of motion
- joint pain
- muscle spasms
- stiffness
- joint swelling

Neurologic

- tingling
- seizures
- tremors
- loss of balance
- headaches
- weakness

Psychiatric

- depression
- anxiety
- difficulty sleeping
- feeling sleepy
- thoughts of suicide

Hematologic

- easy bleeding
- easy bruising
- infection

Patient Signature: _____ Date: _____