

**SARAH E. McMILLAN, MD**  
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Name: (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Primary Concern / Procedure: \_\_\_\_\_  
Primary Care Provider and Phone Number: \_\_\_\_\_  
Referred By: \_\_\_\_\_

**Allergies:**

Drug: \_\_\_\_\_ Reaction(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Latex Allergy: (Y) \_\_\_\_ (N) \_\_\_\_ Environmental: \_\_\_\_\_

**Medical History / Review of Systems:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Have you ever had the following?  
(Please check ANY that apply)

- Heart Disease / Heart Murmur
- Mitral Valve Prolapse
- High Blood Pressure
- Bleeding Tendencies
- Phlebitis
- Hepatitis / HIV
- Anemia
- Herpes (cold sore, genital or shingles)
- Diabetes
- Acid Reflux Disease
- Asthma
- Sleep Apnea / Snoring
- Migraines / Headaches
- Stroke / TIA
- Psychiatric Care
- Arthritis
- Cancer (of \_\_\_\_\_ )

Have you recently had?  
(Please check ANY that apply)

- Fever, chills, nausea, vomiting, diarrhea
- Weight increase, decrease
- Skin rashes, lumps
- Frequent colds, sinus congestion
- Changes in vision, hearing
- Sore throat, bleeding gums
- Lumps in neck
- Breast masses, nipple discharge
- Chest pain, shortness of breath, difficulty breathing
- Heartburn, abdominal pain
- Numbness/tingling/cramping in hands or feet
- Swelling of hands or feet
- Seizures, paralysis
- Anxiety, depression

Any medical problems that we did not mention?: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous Surgeries / Hospitalizations and Date:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Medication(s):

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Family Medical History: \_\_\_\_\_

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Social History:

Use of tobacco:

- I am a non-smoker who has never used tobacco products.  
 I am a former smoker who quit \_\_\_\_\_ months/years ago.  
 I am a current smoker and I smoke \_\_\_\_\_ cigarettes/packs per day.

Use of alcohol:

- I never use alcohol.  
 I occasionally use alcohol. Approximately \_\_\_\_\_ drink(s) per week.  
 I am a regular user of alcohol. Approximately \_\_\_\_\_ drink(s) per day.

Use of drugs:

- I never use drugs.  
 I only use doctor prescribed medications.  
 I use drugs recreationally. Please list: \_\_\_\_\_  
\_\_\_\_\_

Exercise regime: \_\_\_\_\_

Type of employment: \_\_\_\_\_

I hereby declare that the information I have provided on this form is a true and accurate record to the best of my knowledge.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

The following line is to be signed by your doctor or nurse.

\_\_\_\_\_  
Reviewed by

\_\_\_\_\_  
Date