

PATIENT HISTORY FORM

MEDICAL HISTORY

Name _____ Date of Birth _____ Height _____ Weight _____

Reason for seeking medical attention _____

Treatment you've received for this problem, including MRIs, CT scans, labwork, etc. Please include dates _____

Previous Surgical History:

Operation:	Date	Operation:	Date
Operation:		Operation:	
Operation:		Operation:	

Current Medications:

#	Medication	Dose	How Taken	How Often	Last Dose Taken	Why do you take?
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Do you have known medication allergies? Yes No

If yes, please list medications and type of reaction: _____

Do you have an allergy to latex or rubber gloves? Yes No **Allergy to tape?** Yes No

If yes, please describe _____

PAST MEDICAL HISTORY (CHECK APPROPRIATE BOXES) NONE

- | | | |
|--|---|---|
| <input type="checkbox"/> High blood pressure
<input type="checkbox"/> Heart attack (when) _____
<input type="checkbox"/> Heart bypass, Angioplasty, Stent (Date) _____
<input type="checkbox"/> Heart Failure
<input type="checkbox"/> Heart murmur or Heart Valve problem
<input type="checkbox"/> Palpitations or Irregular Heart Beat
<input type="checkbox"/> Asthma, Emphysema, COPD
<input type="checkbox"/> Recent flu or productive cough
<input type="checkbox"/> Pneumonia (Date) _____
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes Mellitus
<input type="checkbox"/> Thyroid Disease _____
<input type="checkbox"/> Brain surgery/injury _____
<input type="checkbox"/> Headaches/Migraines
<input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Stroke (Date) _____
<input type="checkbox"/> Phlebitis/blood clots
<input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Hiatal Hernia
<input type="checkbox"/> Acid reflux or ulcers
<input type="checkbox"/> Hepatitis, Cirrhosis or Jaundiced
<input type="checkbox"/> Kidney failure/Dialysis (Date) _____
<input type="checkbox"/> Phlebitis/blood clots
<input type="checkbox"/> Blood disorder _____
<input type="checkbox"/> Mental Health Issues _____
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Cancer, Chemotherapy/Radiation (Date) _____
Have you recently had:
<input type="checkbox"/> Chest pain or Angina
<input type="checkbox"/> Difficulty breathing, shortness of breath | <input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Easy bruising/bleeding
<input type="checkbox"/> Nerve paralysis or Numbness
<input type="checkbox"/> Fainting/Loss of Consciousness
<input type="checkbox"/> Vision impairment
<input type="checkbox"/> Hearing impairment
<input type="checkbox"/> Back or neck pain
<input type="checkbox"/> Chronic pain _____
<input type="checkbox"/> Muscle Pain
<input type="checkbox"/> Recent Muscle Weakness
<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Rectal bleeding, black/bloody stool
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Constipation
<input type="checkbox"/> Skin problem _____ |
|--|---|---|

Comments: _____

SOCIAL HISTORY

Do you smoke? () Yes () No If yes, how many packs per day? _____ How many years? _____
 Do you drink? () Yes () No If yes, how much do you drink? _____ What do you drink? _____
 Do you use illegal/street drugs? () Yes () No If yes, what do you use? _____
 Do you have a religious affiliation that would affect decisions about your care? () Yes () No
 If yes, please explain _____
 Do you currently follow a special or restricted diet? _____
 Do you have a: () Living Will () Healthcare Power of Attorney () None
 Do you want more information on a Living Will? () Yes () No
 Do you need assistance in caring for yourself at home? () Yes () No

FAMILY HISTORY

Mother living? () Yes () No Age _____ Medical Conditions _____
 If deceased, please indicate cause of death _____
 Father living? () Yes () No Age _____ Medical Conditions _____
 If deceased, please indicate cause of death _____
 Siblings Living? () Yes () No Age _____ Medical Conditions _____
 If deceased, please indicate cause of death _____

PLEASE CHECK YES/NO FOR THE FOLLOWING QUESTIONS

Have you or anyone in your family had an anesthetic reaction? () Yes () No
 Do you bruise without apparent injury? () Yes () No
 Do you have prolonged bleeding after dental extractions? () Yes () No
 Did you have bleeding associated with a previous operation? () Yes () No
 Do you have relatives with a bleeding disorder? () Yes () No
 Have you taken aspirin, coumadin, or any blood thinning medications in the past 10 days? () Yes () No
 Have you had a recent weight loss? () Yes () No
 Do you have a wound that will not heal? () Yes () No
 Have you had blood clots in your legs? () Yes () No
 Have you taken any prednisone or hydrocortisone in the past? () Yes () No
 Do you require antibiotics before surgery or dental procedures? () Yes () No

AUTHORIZATION

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the physician's office of any changes in my medical status.

Signature _____ Date _____