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	Taking Aspirin? Yes No					
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

( ) High blood pressure
( ) Heart attack (when)_____
( ) Heart bypass, Angioplasty, Stent (Date)_____
( ) Heart Failure
( ) Heart murmur or Heart Valve problem
( ) Palpitations or Irregular Heart Beat
( ) Asthma, Emphysema, COPD
( ) Recent flu or productive cough
( ) Pneumonia (Date)_____
( ) Tuberculosis
( ) Diabetes Mellitus
( ) Thyroid Disease_____
( ) Brain surgery/injury_____
( ) Headaches/Migraines
( ) Dementia/Alzheimer's

( ) Stroke (Date)_____
( ) Phlebitis/blood clots
( ) Epilepsy or Seizures
( ) Hiatal Hernia
( ) Acid reflux or ulcers
( ) Hepatitis, Cirrhosis or Jaundiced
( ) Kidney failure/Dialysis (Date)_____
( ) Phlebitis/blood clots
( ) Blood disorder_____
( ) Mental Health Issues_____
( ) Arthritis
( ) Cancer, Chemotherapy/Radiation (Date)_____

Have you recently had:
( ) Chest pain or Angina
( ) Difficulty breathing, shortness of breath

( ) Sleep Apnea
( ) Easy bruising/bleeding
( ) Nerve paralysis or Numbness
( ) Fainting/Loss of Consciousness
( ) Vision impairment
( ) Hearing impairment
( ) Back or neck pain
( ) Chronic pain_____
( ) Muscle Pain
( ) Recent Muscle Weakness
( ) Abdominal Pain
( ) Rectal bleeding, black/bloody stool
( ) Diarrhea
( ) Constipation
( ) Skin problem_____

Comments:_____
_____

 Patient Name_____

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_____