

# PATIENT MEDICAL HISTORY

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_ ft \_\_\_ in Weight: \_\_\_\_\_ lbs.

1. Problem/Condition that you are being seen for today: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Date problem began: \_\_\_\_\_

2. Other current/past medical conditions (for example: Diabetes, heart attack, etc.) \_\_\_\_\_  
\_\_\_\_\_

3. Previous Surgeries: \_\_\_\_\_  
\_\_\_\_\_

4. Do you have any allergies?  Yes  No (If yes, please check all that apply)  
 Aspirin  Codeine  Penicillin  Sulfa  Cortisone/Prednisone  Latex  
Please list any other allergies: \_\_\_\_\_  
Please describe reaction:  Hives/Itching  Nausea/Vomiting/Diarrhea  Shock/Unconsciousness  
 Anemia/Blood Disorder  Asthma/Shortness of Breath  Other \_\_\_\_\_

5. Current Medications:

Name of Medication	Dosage/Strength 50 mg, etc	How often taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Please answer the following as honestly as possible (answers are confidential):

A. Do you use alcohol  Yes  No  
If yes, how much and how often? \_\_\_\_\_

B. Do you smoke or use tobacco products?  Yes  No  
If yes, how much and how often? \_\_\_\_\_

C. Have you ever used IV or Street Drugs?  Yes  No  
If yes, type and how often \_\_\_\_\_

## PATIENT MEDICAL HISTORY

Please check if you have (or have had) any of the following medical conditions:

### RESPIRATORY

Lung Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Trouble Breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coughed up Blood	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abnormal Chest X-ray	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### CIRCULATORY

Heart Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Severe Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Valve Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### ENDOCRINOLOGY

Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### DIGESTIVE

Heartburn	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vomiting of Blood	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Black or Tarry Stools	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Yellow Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gallbladder Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood in your Stool	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### MUSCULOSKELETAL

Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Previous Joint Replacement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prosthetics, Artificial Arteries, Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### HEMATOLOGY

Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding or Bruising Easily	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### URINARY

Bladder Infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood or Pus in Urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Stones	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### NEUROLOGICAL

Convulsions or Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neurological Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please specify:

Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Paralysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nervous Breakdown	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychiatric Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please specify:

### OB/GYN

Tumor, cyst of breast	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last menstrual period:		
Are you or could you be pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### CANCER

Have you been diagnosed with any type of Cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, what type?

### ANESTHESIA

Have you ever had problems with anesthesia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, please describe:

## FAMILY HISTORY

If you have **no family history** of any of the problems listed below, please

initial here \_\_\_\_\_. Otherwise please check all that apply below.  
(CHECK ALL THAT APPLY)

### RESPIRATORY

Lung Trouble	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
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### CIRCULATORY

Heart Trouble	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Heart Attack	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
High Blood Pressure	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Heart Valve Problems	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister

### ENDOCRINOLOGY

Thyroid Disease	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Diabetes	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister

### DIGESTIVE

Liver Trouble	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Gallbladder Trouble	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister

### MUSCULOSKELETAL

Rheumatoid Arthritis	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
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### HEMATOLOGY

Anemia	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Bleeding or Bruising easily	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister

HIV/AIDS	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
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### URINARY

Kidney Disease	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
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### NEUROLOGICAL

Convulsions or Seizures	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Neurological Disease	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Stroke	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Paralysis	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Nervous Breakdown	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Psychiatric Condition	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister

### OB/GYN

Tumor, cyst of breast	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Parent	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
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### CANCER

Type of Cancer:

Who? (check all that apply)  Grandparent  Parent  Brother  Sister

Type of Cancer:

Who? (check all that apply)  Grandparent  Parent  Brother  Sister

Type of Cancer:

Who? (check all that apply)  Grandparent  Parent  Brother  Sister

### ANESTHESIA

Problems with Anesthesia?  Yes  No

Who? (check all that apply)  Grandparent  Parent  Brother  Sister