

Today's Date _____
 Updated Dates _____

PATIENT MEDICAL HISTORY

Name: _____ Birthdate: _____
 Last First Middle (Month/Day/Year)

PERSONAL HISTORY OF ILLNESS: (Check any illness, past or present)

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Asthma | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Skin Trouble |
| <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout/Arthritis |
| <input type="checkbox"/> Epilepsy (seizure) | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Eye Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Recurrent Ear Infection |
| <input type="checkbox"/> Other _____ | | | | |

SURGERIES AND HOSPITALIZATIONS

| Year | Surgery or reason for hospitalization | Year | Surgery or reason for hospitalization |
|----------|---------------------------------------|----------|---------------------------------------|
| 1. _____ | _____ | 5. _____ | _____ |
| 2. _____ | _____ | 6. _____ | _____ |
| 3. _____ | _____ | 7. _____ | _____ |
| 4. _____ | _____ | 8. _____ | _____ |

ALLERGIES

Are you allergic to any medications? Yes No If yes, what? _____
 Any other allergies (latex, rubber, etc.)? _____

FAMILY HISTORY

Is there any history of the following diseases in your family? If yes, indicate which relative.

| <u>DISEASE</u> | <u>WHICH RELATIVE</u> | <u>DISEASE</u> | <u>WHICH RELATIVE</u> |
|---------------------|-----------------------|------------------------|-----------------------|
| Cancer | _____ | Heart Disease | _____ |
| Stroke | _____ | High Blood Pressure | _____ |
| Diabetes | _____ | Tobacco/Alcohol Abuse | _____ |
| Asthma/Lung Disease | _____ | Reaction to Anesthesia | _____ |
| Depression | _____ | Other | _____ |

SOCIAL HISTORY

Married Widowed Single Divorced Occupation: _____
 Are you in a relationship where you feel unsafe: Yes No
 Children: No Yes - How many _____ Caffeine use: No Yes - How much _____
 Exercise: No Yes - How often _____ (coffee, tea, cola)
 Drug Use: No Yes - How often _____ Alcohol use: No Yes - How much _____
 (Marijuana, LSD, Speed, Heroin, Methamphetamine, etc.) (including beer and wine)
 Tobacco use: No If quit, how long did you smoke? _____ Yes - How much _____ Year began _____

Do you have a Living Will/Advanced Directives? Yes No Do we have a copy? Yes No