

# PATIENT MEDICAL HISTORY

NAME \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_ Chart # \_\_\_\_\_

## SURGERIES

Please check the correct box below:

List dates & diagnosis:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

	No	Yes
Have you ever been advised to have surgery which was not done?	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had a blood or plasma transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

## HOSPITALIZATIONS

List dates and diagnosis:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## ILLNESS

	No	Yes
Have you ever had:		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Other Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headache	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis, Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>
Herpes, Other STD	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

## INJURIES

	No	Yes
Have you ever had:		
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>
Dislocations	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to anyone except when you have authorized us to do so.

## ALLERGIES

	No	Yes
Are you allergic to:		
Penicilin	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa	<input type="checkbox"/>	<input type="checkbox"/>
Other Drugs: _____		

Any Foods: \_\_\_\_\_

Other: \_\_\_\_\_

## IMMUNIZATIONS

	No	Yes
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

## SOCIAL HISTORY

	No	Yes
Employed As:		
Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>
How Much _____		
Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>
How Much _____		
Other Drugs	<input type="checkbox"/>	<input type="checkbox"/>
How Much _____		
Any Pets	<input type="checkbox"/>	<input type="checkbox"/>
What Kind _____		
Hobbies _____		

Any travel outside the USA?	<input type="checkbox"/>	<input type="checkbox"/>
Where _____		

Do you have well water?  No  Yes

How many people live in your home? \_\_\_\_\_