

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