PATIENT HEALTH HISTORY (Page 1 of 2) DATE: ______________________

NAME: ______________________ AGE: ______________________

HEIGHT: ______________________ SEX: ______________________

Please state the reason you are seeing the doctor: ______________________

Medical Problems (high blood pressure, heart attack, stroke, arthritis, fibromyalgia, etc):

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Medications, including vitamins, hormones, steroids, aspirin, or over-the-counter (supply dosage where possible):

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Allergies to medications/adverse reactions to medications taken previously?

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Previous surgeries:

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Any complications experienced from anesthesia or surgery itself?

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Any history of sleep apnea?

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Any use of tobacco products, alcohol, or illicit drugs?

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Family History: Do you have a family history of any of the following disorders?

Yes	No	Breast Cancer	Yes	No	Diabetes	Yes	No	Lung Disease
Yes	No	Bleeding or Blood Disorders	Yes	No	Epilepsy	Yes	No	Heart Problems
Yes	No	Cancer _____________	Yes	No	Asthma	Yes	No	Kidney Disease
Yes	No	Tuberculosis (T.B.)	Yes	No	Stroke	Yes	No	Hypertension

The above information is true and correct to the best of my knowledge:

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Signature of Patient or Responsible Guardian

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Signature of Physician

Have you ever had any of the following problems?

NAME: ______________________________

LUNGS (PULMONARY)	YES	NO
Asthma		
Tuberculosis (T.B.)		
Chronic or Frequent Cough		
Abnormal Chest X-Ray		
Lung Disease		
Chronic Nose/Sinus Complaints		
Shortness of Breath		
Smoking		

HEMATOLOGIC	YES	NO
Blood Clots in Your Legs		
Pulmonary Embolism		
Phlebitis		
Varicose Veins		
Spider Veins		
Blood Clotting Abnormalities		
Blood or Plasma Transfusion		
Hemophilia		
Recurrent Nosebleeds		

GASTROINTESTINAL	YES	NO
Jaundice or Hepatitis		
Liver Disease		
Stomach Ulcers		
Frequent Heartburn		
Hernia		

RENAL	YES	NO
Kidney Disease/Stones		
Frequent Bladder Infections		
Prostate Problems		

SKIN	YES	NO
Skin Cancer		
Hives, Eczema, Rashes		
Form Large Scars/Keloids		
ACTH/Steroid Medications (Excluding skin creams/lotions)		
Allergic to Latex or Suture		
Frequent Infections/Boils		
Cold Sores/Fever Blisters		
Genital Herpes		
Have you ever been diagnosed with MRSA?		

NEUROLOGICAL	YES	NO
Stroke		
Fainting Spells		
Convulsions		
Epilepsy		
Migraine Headaches		
Adult Attention Deficit Disorder		
Bipolar		

MAMMOGRAM	YES	NO
Have you had a mammogram?		
If yes, when?		

CARDIOVASCULAR	YES	NO
Mitral Valve Prolapse		
Anemia		
High Blood Pressure		
Chest Pain/Angina		
Heart Attack		
Irregular Heartbeats		
Rheumatic Fever		
Heart Murmurs		
Low Potassium		
Abnormal EKG (Heart Recording)		
Pacemaker		
Any Heart Disease		
Sickle Cell Disease		

MUSCULOSKELETAL	YES	NO
Chronic Back/Neck Pain		
Arthritis		
Bone, Joint, Muscle Trouble		

METABOLIC	YES	NO
Recent Unexpected Weight Loss/Gain		
Diabetes		
Thyroid/Goiter Problems		
Changes in Thyroid Medications		
Night Sweats/Fever		
AIDS (HIV +)		
Sensitive to Cold Temperatures		
Changes in Skin		
Loss of Hair		
Frequent Constipation		
Menstrual Changes		
Tired Often		

EYES	YES	NO
Glaucoma		
Loss of Vision		
Wear Glasses or Contacts		
Double Vision		
Dryness		
Corneal Injury		

MENTAL		
Do you have, or have you had emotional problems?		
Any recent emotional crisis?		
Any verbal or sexual abuse?		
History of substance abuse?		

PREGNANCY	YES	NO
Any possibility you are pregnant?		
Have you had a tubal ligation or hysterectomy?		

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Signature of Patient or Responsible Guardian