

MEDICAL HISTORY

NAME: _____ DATE: _____

“PLEASE CIRCLE YES OR NO TO ALL QUESTIONS REGARDING PATIENT’S HEALTH”

Do you (patient) have a history of:

- | | | |
|---|-----|----|
| Anemia | Yes | No |
| Angina | Yes | No |
| Arthritis/Gout | Yes | No |
| Asthma | Yes | No |
| Diabetes | Yes | No |
| Leukemia | Yes | No |
| Cancer | Yes | No |
| Abnormal Bleeding or Blood Clots | Yes | No |
| Glaucoma | Yes | No |
| Heart Disease | Yes | No |
| Heart Attack | Yes | No |
| Arrhythmia | Yes | No |
| Ulcers | Yes | No |
| Kidney Disease | Yes | No |
| Liver Disease | Yes | No |
| Lung Disease | Yes | No |
| Hypertension | Yes | No |
| Use of a blood thinner | Yes | No |
| Malignancy | Yes | No |
| Chemotherapy | Yes | No |
| Shortness of breath with daily activities | Yes | No |
| Pulmonary Disease | Yes | No |
| Stroke | Yes | No |
| Neurologic Disease: | Yes | No |
| TYPE _____ | | |
| Exposed to Tuberculosis | Yes | No |
| Steroid Use | Yes | No |
| Recent infection (include dental) | Yes | No |
| Thyroid | Yes | No |

Social History:

Marital Status:
Married _____ Single _____
Divorced _____ Widowed _____

FEMALES - PLEASE ANSWER:

PRESENTLY PREGNANT
YES NO
TAKE BIRTH CONTROL PILLS
YES NO

Use of Alcohol:

Never _____ Rarely _____
Moderate _____ Daily _____

Use of Drugs:

Never _____
Type/frequency _____

Use of Tobacco:

Never _____ Previously, but quit _____
Yes _____
Current packs per day ____ ____

FAMILY HISTORY:

Father's Age _____ Illness or Disease

If deceased, cause: _____

Mother's Age _____ Illness or Disease

If deceased, cause: _____

ANY OTHER HEALTH INFORMATION:

LIST ALL ALLERGIES:

LIST ANY PAST SURGERIES, HOSPITALIZATIONS AND SERIOUS INJURIES: (INCLUDE DATES)

PRESENT MEDICATIONS:

Patient's Weight _____