Patient Medical History Sheet

Patient Name: ______________________________ Date of Birth:____________________ Date: __________

Occupation: ______________________________ Allergies:__________________________________________

MEDICAL HISTORY-Check (X) where appropriate

| YOU | RELATIVE | | YOU | RELATIVE | |
|---|---|---|---|---|---|
| ________ | ________ | Diabetes Mellitus | ______ | _____ | Reflux/Hiatal Hernia |
| ________ | ________ | Migraines/Headaches | ______ | _____ | Swallowing/Esophageal Problems |
| ________ | ________ | High Cholesterol/Triglycerides | ______ | _____ | Glaucoma/Vision Problems |
| ________ | ________ | High Blood Pressure | ______ | _____ | Seizures |
| ________ | ________ | Heart Disease/Attack | ______ | _____ | AIDS/HIV |
| ________ | ________ | Heart Failure/Valve | ______ | _____ | Liver Problems |
| ________ | ________ | Hearing Problems/Loss | ______ | _____ | Hepatitis/Cirrhosis |
| ________ | ________ | Cancer type | ______ | _____ | Stomach Ulcers/Gastritis |
| | | 1. ______________________ | ______ | _____ | Arthritis |
| | | 2. ______________________ | ______ | _____ | Rheumatoid/Lupus/Gout |
| ________ | ________ | Lung Disease | ______ | _____ | Osteoarthritis |
| ________ | ________ | Empysema/COPD | ______ | _____ | Thyroid Problems |
| ________ | ________ | Asthma | ______ | _____ | Skin Diseases |
| ________ | ________ | TB/PPD | ______ | _____ | Clotting/Bleeding disorders |
| ________ | ________ | Orthopedic Problems | ______ | _____ | Kidney Problems/Stones |
| ________ | ________ | Colitis | ______ | _____ | Depression/ Anxiety |
| ________ | ________ | Vascular disease(Aneurysm) | ______ | _____ | Anemia(Iron,B12) |
| ________ | ________ | Neuromuscular/MS | ______ | _____ | Other: ______________________ |

Please explain which relative below:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

SURGICAL HISTORY: Please list all surgeries and dates(if possible)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

MEDICATION AND DOSAGE: (Prescription, over the counter,vitamins, etc)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

SOCIAL HISTORY: Check (X) where appropriate

__ Tobacco __ How many packs/day? __ How many years?

______ Alcohol _____ How many drinks per week?

_______ Drugs ______________________________

_____ Coffee or tea ______ How many cups/day

___Have you ever had a blood transfusion?

______ Do you wear seatbelts?

_____Is there a gun in the home? _____Is it locked & ammo key separ

______ Do you have smoke detectors on every floor?

_______ Do you exercise regularly?

_____ Are you on a special diet?

_______ Engaged in risky sexual behavior?

_______ Have you ever come into contact with hazardous materials?

________ Are you in a relationship where you have been physically hurt?

______ Do you wear a bike helmet?

______ Do you have a living will?

______ Do you have a power of attorney?

_______ Are you an organ donor?