

MEDICAL HISTORY

Please assist us in providing quality medical care by completing this form. If unsure about any of the answers, please discuss with the doctor or nurse.

PATIENT'S NAME _____ DATE _____

PRIMARY CARE (Family) DOCTOR _____

OTHER TREATING DOCTORS _____

HEIGHT _____ WEIGHT _____ (If unknown, please guess)

SMOKING: Never, Quit _____, Packs per day _____, ALCOHOL: NO, Drinks/week _____

CAFFEINE: NO, Servings/day _____ Occupation _____

Married ___ Single ___ Child living with: Mother ___ Father ___ Both ___ Other _____

FAMILY HISTORY *Do any of your blood relatives have, or had, any of the following?* (please circle) Bleeding problems, Diabetes, Heart disease, High blood pressure, Cancer, Hearing loss, Sickle cell Disease, problems with anesthesia (explain) _____

NONE OF THESE

ALLERGIES TO MEDICATION: NONE KNOWN, YES (LIST BELOW)

MEDICATIONS you are taking (include NAME, STRENGTH, and FREQUENCY) NONE

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

MEDICAL PROBLEMS: NONE, _____

PRIOR SURGERIES: NONE, _____

CIRCLE any of the below conditions which you now have, have had in the past, or may have had. If you are unsure, indicate with question marks and discuss with the doctor.

Diabetes, Thyroid disease, Bleeding problems, Problems with anesthesia (explain) _____

NONE OF THESE

(continued on back)

High blood pressure, Heart attack, Heart murmur, Abnormal heart beats, Heart valve problems, Chest pain, Leg pain on walking, Poor circulation, Blood clots in legs, Leg swelling, Heart failure, Stroke, Sickle cell disease NONE OF THESE

Asthma, Emphysema, Chronic cough, Shortness of breath, Coughing blood, Wheezing, Positive TB test NONE OF THESE

Swallowing problems, Heartburn, Frequent burping, Unusual vomiting, Vomiting blood, Stomach pain, Unusual diarrhea or constipation, Hepatitis, Liver disease, Blood in stool, Black stools, Unusual weight loss or gain NONE OF THESE

Difficulty urinating, Blood in urine, Leakage of urine, Kidney disease NONE OF THESE

Seizures, Numbness or tingling, Weakness of an arm or leg, Visual problems (other than needing glasses) NONE OF THESE

Hearing loss, Ear noises, Spinning sensation, Imbalance, Ear pain, Frequent sneezing, Runny nose, Post-nasal drainage, Nasal blockage, Recurrent bloody noses, Facial pain, Sore throat, Bad breath, Hoarseness NONE OF THESE

WOMEN ONLY:

If you think you MIGHT be pregnant, please notify us as soon as possible if SURGERY is being scheduled, or MEDICATION is being prescribed.

Form completed by: Self _____, Mother _____, Father _____

*****for office use only*****

Reviewed by _____