

# PATIENT HISTORY FORM

LAST NAME \_\_\_\_\_

FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

Single  Married  Widowed  Divorced

ALLERGIES: \_\_\_\_\_

Smoke? NO YES, how much? \_\_\_\_\_

Drink alcohol? NO YES, how much? \_\_\_\_\_

## PAST MEDICAL HISTORY

**CONDITIONS:** Check any conditions you have had in the PAST

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> abnormal pap       | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> polio                   |
| <input type="checkbox"/> anorexia/bulimia   | <input type="checkbox"/> headache/migraines  | <input type="checkbox"/> prostatitis             |
| <input type="checkbox"/> arthritis/gout     | <input type="checkbox"/> hernia              | <input type="checkbox"/> psychiatric care        |
| <input type="checkbox"/> asthma/emphysema   | <input type="checkbox"/> hepatitis           | <input type="checkbox"/> sexually trans. Disease |
| <input type="checkbox"/> blood disorders    | <input type="checkbox"/> high cholesterol    | <input type="checkbox"/> stroke/TIA              |
| <input type="checkbox"/> breast lump        | <input type="checkbox"/> HIV positive        | <input type="checkbox"/> substance abuse         |
| <input type="checkbox"/> cancer             | <input type="checkbox"/> kidney disease      | <input type="checkbox"/> thyroid problems        |
| <input type="checkbox"/> chicken pox        | <input type="checkbox"/> leg cramps          | <input type="checkbox"/> TB                      |
| <input type="checkbox"/> cataracts/glaucoma | <input type="checkbox"/> liver disease       | <input type="checkbox"/> ulcers                  |
| <input type="checkbox"/> diabetes           | <input type="checkbox"/> irregular periods   | <input type="checkbox"/> urinary problems        |
| <input type="checkbox"/> epilepsy           | <input type="checkbox"/> multiple sclerosis  | <input type="checkbox"/> vaginal infections      |
| <input type="checkbox"/> heart disease      |  |  |

Other: \_\_\_\_\_

**\*Date of last Tetanus Shot**

## SURGERIES / HOSPITALIZATIONS

YEAR REASON FOR HOSPITALIZATION

_____	_____
_____	_____
_____	_____

## CURRENT MEDICATIONS

_____
_____
_____
_____

## FAMILY HISTORY

Relation Age State of health Age at death Cause

Father

Mother

Sisters

Brothers

Grandparents

Check if your blood relatives had any of the following Diseases:

Relationship

- Arthritis
- Asthma
- Cancer
- Diabetes
- High Blood pressure
- Heart disease
- Stroke
- Kidney disease

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_