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PATIENT MEDICAL HISTORY FORM

PATIENT NAME: LAST ______________________ FIRST ______________ M.I. ______

MEDICAL CONDITIONS

Please list any past medical problems, even if corrected with current medications:

SURGICAL HISTORY / TRAUMA HISTORY

Please list all operations or injuries you have had:

DESCRIPTION	MONTH / YEAR	HOSPITAL

Have you or any family members ever had a reaction to anesthesia? ____________ **Bleeding problems?** ____________

MEDICATIONS

List current medications including non-prescription items (e.g. Dietary Supplement, Diet Pills, Cold & Flu Medications, etc.)

NAME	DOSAGE & FREQUENCY	REASON

Have you taken any of the following in the last month? Prednisone ______ Coumadin ______ Aspirin/Motrin/Naprosyn ______

Please list medications to which you are allergic: ______________________

REVIEW OF SYSTEMS

Please check the box if you are currently experiencing a symptom

☐ Fevers	☐ Ankle Swelling	☐ Vomiting	☐ Breast Lump / Pain
☐ Fatigue	☐ Calf Pain	☐ Upper Abdominal Pain	☐ Nipple Discharge
☐ Weight Changes	☐ Shortness of Breath	☐ Lower Abdominal Pain	☐ Headache or Migraines
☐ Vision Changes	☐ Sob with Exertion	☐ Jaundice	☐ Dizziness
☐ Hearing Loss	☐ Irregular Pulse	☐ Painful Urination	☐ Room Spinning
☐ Ringing in Ears	☐ Wheezing	☐ Blood in Urine	☐ Seizures
☐ Ear Pain	☐ Cough/Sputum	☐ Straining on Urination	☐ Passing Out
☐ Bloody Nose	☐ Coughing Blood	☐ Kidney Stones	☐ Numbness or Tingling
☐ Nasal Discharge	☐ Diarrhea	☐ Pelvic Pain	☐ Memory Loss
☐ Sinusitis	☐ Constipation	☐ Vaginal Discharge / Bleeding	☐ Anxiety
☐ Sore Throat	☐ Stool Incontinence	☐ Joint or Muscle Pain	☐ Depression
☐ Hoarseness	☐ Black Tarry Stool	☐ Decreased Mobility/Weakness	☐ Suicidal Thoughts
☐ Oral Ulcers	☐ Bloody Stool	☐ Joint Swelling / Skin Rash	☐ Excessive Thirst
☐ Chest Pain	☐ Difficulty Swallowing	☐ Itching	☐ Excessive Urination
☐ Palpitations	☐ Heartburn	☐ Mole Change	☐ Easy Bruising
☐ Swollen Nodes	☐ Nausea	☐ Loss of Hair / Brittle Nails	☐ Bleeding Tendency

SOCIAL HISTORY

Marital Status ______ Number of Children ______ International Travel? ______________

Occupation ______________ Do you do heavy lifting on a daily basis? ______

Cigarette Smoking ______ Current ______ Past No of Packs per Day ______ Drug Use? ______________

Alcohol Intake ______ None ______ Occasional ______ 1-2 drinks per day ______ More than 2 drinks per day

FAMILY HISTORY

Check the box if you have a first degree relative (parent or sibling) with the following conditions:

Breast Cancer ____ Ovarian Cancer ____ Skin Cancer ____ Lymphoma ____ Leukemia ____ Inflammatory Bowel Disease ____

Brain Tumors ____ Heart Disease ____ Thyroid Disease ____ Parathyroid Disease ____ Other ______________

The undersigned has carefully and fully reviewed the information provided and acknowledges it is complete to the best of my knowledge.

______________________ ______________________ ______________

Patient or Legal Guardian Signature Print Patient Name or Legal Guardian Date