

MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: _____ DATE: _____

REASON YOU ARE HERE: _____ AGE: _____

REFERRING DOCTOR: _____ PRIMARY CARE DOCTOR: _____

ALLERGIES (INCLUDE: MEDICATIONS, FOOD, AND TOPICALS SUCH AS TAPE OR LATEX **AND TYPE OF REACTION**)

PAST MEDICAL HISTORY DO YOU HAVE NOW OR HAVE YOU EVER BEEN TREATED FOR (CIRCLE YES OR NO):

CANCER YES NO TYPE OF CANCER _____	GASTROINTESTINAL YES NO BLEEDING YES NO CIRRHOSIS YES NO CONSTIPATION YES NO DIARRHEA YES NO DIVERTICULOSIS YES NO GALLBLADDER PROBLEMS YES NO HEMORRHOIDS YES NO HEPATITIS YES NO HIATAL HERNIA YES NO ULCERS YES NO OTHER _____	MUSCULOSKELETAL YES NO ARTHRITIS / BURSITIS YES NO BACK PROBLEMS YES NO OSTEOPOROSIS YES NO VARICOSE VEINS YES NO PHLEBITIS
CARDIAC YES NO MITRAL VALVE PROLAPSE YES NO OTHER VALVE PROBLEMS YES NO CHEST PAIN YES NO HEART ATTACK YES NO HIGH BLOOD PRESSURE YES NO CONGESTIVE HEART FAILURE YES NO IRREGULAR HEART BEAT YES NO HIGH CHOLESTEROL YES NO PACEMAKER YES NO OTHER _____	GYNECOLOGICAL YES NO CURRENTLY PREGNANT _____ NUMBER OF PREGNANCIES _____ NUMBER OF CHILDREN AGE AT FIRST MENSTRUAL PERIOD _____ DATE OF LAST MENSTRUAL PERIOD _____ YES NO MENOPAUSE YES NO OTHER _____	NEUROLOGICAL YES NO FAINTING YES NO DIZZY SPELLS YES NO STROKE YES NO OTHER _____
ENDOCRINE YES NO ABNORMAL WEIGHT GAIN YES NO ABNORMAL WEIGHT LOSS YES NO DIABETES YES NO THYROID PROBLEMS	HEMATOLOGIC YES NO ANEMIA YES NO BLOOD CLOTS YES NO HIV YES NO TAKING BLOOD THINNERS (ASPIRIN / COUMADIN / PLAVIX) YES NO OTHER _____	PSYCHOLOGICAL YES NO ANXIETY YES NO PANIC ATTACKS YES NO DEPRESSION YES NO SLEEP DISTURBANCES
EYES YES NO GLAUCOMA YES NO VISION PROBLEMS		PULMONARY YES NO ASTHMA YES NO CHRONIC BRONCHITIS YES NO EMPHYSEMA YES NO PNEUMONIA YES NO PULMONARY EMBOLISM (PE) YES NO TUBERCULOSIS (TB)
RENAL / GENITOURINARY YES NO KIDNEY STONES YES NO KIDNEY FAILURE YES NO KIDNEY / BLADDER INFECTION		

PAST SURGICAL HISTORY (INCLUDE DATES)

FAMILY HISTORY INCLUDE: (1) AGE (2) MEDICAL PROBLEMS (3) CAUSE OF DEATH (SUCH AS DIABETES, CANCER, STROKE, HEART DISEASE **DO NOT GIVE NAMES**)

FATHER _____
MOTHER _____
BROTHER(S) _____
SISTER(S) _____
GRANDPARENTS _____
AUNT(S) / UNCLE(S) _____

SOCIAL HISTORY

MARITAL STATUS O MARRIED O SINGLE O WIDOWED O DIVORCED	TOBACCO USE YES NO O CIGARETTES O CIGARS O PIPE O SMOKELESS O QUIT DATE _____ O # OF PACKS PER DAY _____ O # OF YEARS _____	ALCOHOL & DRUG USE YES NO ALCOHOL AMOUNT _____ YES NO MARIJUANA YES NO OTHER DRUGS
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JOB: _____

WILL YOU ALLOW TRANSFUSION OF BLOOD OR BLOOD PRODUCTS? YES NO