



# MEDICAL HISTORY FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Past Medical History None

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Asthma                                   | <input type="checkbox"/> Anemia                      | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Stroke                                   | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Heart Murmur         |
| <input type="checkbox"/> Irregular heartbeat                      | <input type="checkbox"/> Heart Attack/CAD            | <input type="checkbox"/> Pneumonia            |
| <input type="checkbox"/> Emphysema                                | <input type="checkbox"/> Pulmonary Emboli/Blood clot | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> GERD/Reflux                              | <input type="checkbox"/> Liver Disease               | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Degenerative Arthritis                   | <input type="checkbox"/> Osteoporosis                | <input type="checkbox"/> Gout                 |
| <input type="checkbox"/> Kidney problems                          | <input type="checkbox"/> Prostate problems           | <input type="checkbox"/> Multiple Sclerosis   |
| <input type="checkbox"/> Skin rashes/Psoriasis                    | <input type="checkbox"/> HIV/AIDS                    | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Cancer, specify type and treatment _____ |  |   |

### Past Surgical History

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia?  No  Yes  
 Have any problems with anesthesia?  No  Yes, describe: \_\_\_\_\_

### Family History

Member	Alive	Deceased	Age	Health Status or Cause of Death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfathers (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Do your parents, siblings, or grandparents have any of the following? Please check all that apply  
 Bleeding disorders     Diabetes     Heart disease     Stroke  
 High blood pressure     Rheumatoid Arthritis     Osteoporosis     Problems with anesthesia  
 Cancer, specify type \_\_\_\_\_     Genetic disorder, specify type \_\_\_\_\_

### Social History

Employed     Unemployed     Retired     Disabled     Student  
 Single     Married     Divorced     Separated     Widowed  
 Children?     No     Yes # \_\_\_\_\_  
 Do you live alone?  No     Yes  
 Exercise?     Daily     Weekly     Monthly     Rarely     Never  
 What type of exercise? \_\_\_\_\_  
 History of substance abuse?     No     Yes    What? \_\_\_\_\_  
 Smoke currently?  No     Yes \_\_\_\_\_ packs per day for \_\_\_\_\_ years     Never smoked  
 Quit Smoking?     This year     >1 year     >5 years     >10 years  
 Previously smoked \_\_\_\_\_ packs per day for \_\_\_\_\_ years  
 Drink alcohol     how many drinks per week \_\_\_\_\_     daily     1-2x/week     1-2x/month     1-2x/year

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_ Pg. 2