Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Patient History

Please answer every question.

STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

PAST MEDICAL HISTORY

Please indicate if YOU have a history of the following:

PAST	CURRENT		PAST	CURRENT	
○	○	Anemia	○	○	Heart Attack
○	○	Appendicitis	○	○	Heart Murmur
○	○	Arthritis	○	○	Heart Palpitations
○	○	Asthma	○	○	Hepatitis
○	○	Bladder Infection	○	○	Hernia
○	○	Cancer	○	○	High Blood Pressure
○	○	Congestive Heart Failure	○	○	Phlebitis (Vein Swelling)
○	○	COPD	○	○	Pleurisy
○	○	Deep Vein Thrombosis (DVT)	○	○	Pneumonia
○	○	Diabetes (Type 2 Adult Onset)	○	○	Rheumatic Fever
○	○	Insulin Dependent	○	○	Stroke
○	○	Emphysema	○	○	Thyroid Problems
○	○	Esophagitis	○	○	Tuberculosis
○	○	Gallbladder Problems	○	○	Ulcers
○	○	Glaucoma	○	○	Urinary Tract Infection (UTI)
○	○	Head Injury	○		**NO MEDICAL HISTORY**

Other Disease, Cancer or Significant Medical Illness (please specify): _____

SURGICAL HISTORY

Please mark all surgeries you have had:

- ○ **I HAVE HAD NO SURGERIES**
- ○ Ankle
- ○ Adenoidectomy
- ○ Appendectomy
- ○ Arthroscopy Knee
- ○ Back
- ○ Breast
- ○ Carpal Tunnel
- ○ Cataract
- ○ Cath Stent Placement
- ○ Cervical Vertebral Fusion
- ○ Cesarean Section
- ○ Coronary Artery Bypass
- ○ Deviated Septum Repair
- ○ Ear Tubes
- ○ Elbow
- ○ Eye
- ○ Foot
- ○ Gallbladder
- ○ Gastric
- ○ Heart Stent
- ○ Hemorrhoidectomy
- ○ Hernia Repair
- ○ Hip
- ○ Hip Replacement
- ○ Hysterectomy
- ○ Knee Replacement
- ○ Lumbar Vertebral Fusion
- ○ Lumpectomy
- ○ Rotator Cuff Repair
- ○ Shoulder
- ○ Thyroid
- ○ Tonsillectomy
- ○ Tubal Ligation
- ○ Vein Stripping
- ○ Wrist

Other Surgery or Hospitalization (please specify): _____

MEDICATIONS

Please bring a current list of all medications. Alternately, fill in chart below:

Include prescription medications, over the counter medications and herbal supplements. (e.g., aspirin, vitamins, herbs, etc.)

○ **I AM NOT CURRENTLY TAKING ANY MEDICATIONS**

Name	Dosage	Frequency

Name	Dosage	Frequency

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Patient History

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ALLERGIES

Are you allergic to any drugs / medications?

- I HAVE NO KNOWN ALLERGIES TO MEDICATIONS
- Aspirin
- Codeine
- Morphine
- NSAIDS (e.g., ibuprofen, naproxen, etc.)
- Penicillin
- Sulfa
- Other (please specify): _____

Are you allergic to any environmental allergens?

- I HAVE NO KNOWN ENVIRONMENTAL ALLERGIES
- Animal Dander
- Bee Stings
- Eggs
- Food Dye
- Latex
- Mold
- Nuts
- Pollen
- Shellfish
- Other (please specify): _____

FAMILY MEDICAL HISTORY

- Family History UNKNOWN
- ADOPTED
- NO SIGNIFICANT FAMILY MEDICAL HISTORY

Please indicate which family member(s) have had these illnesses:	Father	Mother	Grandmother *Mother's side*	Grandfather *Mother's side*	Grandmother *Father's side*	Grandfather *Father's side*	Brother	Sister
Arthritis	◯	◯	◯	◯	◯	◯	◯	◯
Blood / Clotting Disorders	◯	◯	◯	◯	◯	◯	◯	◯
Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Diabetes (Type 2 Adult Onset)	◯	◯	◯	◯	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯	◯	◯	◯	◯
Kidney Disease	◯	◯	◯	◯	◯	◯	◯	◯
Rheumatoid Arthritis	◯	◯	◯	◯	◯	◯	◯	◯
Stroke	◯	◯	◯	◯	◯	◯	◯	◯

Your Mother is: ◯ living ◯ deceased — If deceased, age and cause of death: _____

Your Father is: ◯ living ◯ deceased — If deceased, age and cause of death: _____

SOCIAL HISTORY

ALCOHOL USE

Do you drink alcoholic beverages? ◯ yes ◯ no ◯ social drinker

If yes, how many drinks per week? ◯ 7 or less ◯ 8-14 ◯ 15 or more

TOBACCO USE

Smoking status: ◯ never ◯ previous ◯ current (some days) ◯ current (everyday)

How many packs per day do you (or did you) smoke? ◯ less than 1 ◯ 1-2 ◯ more than 2

How many years have you (or did you) smoke? ◯ less than 1 ◯ 1-5 ◯ 6-10 ◯ 11-15 ◯ 16-20 ◯ 21+

MARITAL STATUS ◯ single ◯ currently married ◯ divorced ◯ widow / widower

WORK HISTORY ◯ office worker ◯ homemaker

Occupation: ◯ outdoor worker ◯ retired ◯ other _____

RACE ◯ Native American ◯ Caucasian ◯ African American ◯ prefer not to answer ◯ other _____

ETHNICITY ◯ Hispanic or Latino ◯ Non-Hispanic or Latino ◯ prefer not to answer

LANGUAGE ◯ English ◯ Spanish ◯ prefer not to answer ◯ other _____

OTHER

Any person, family or job problem(s) that might affect your situation / recovery? ◯ no ◯ yes _____