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

Patient History

Please answer every question and return to the front desk.

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

PLEASE PRINT PATIENT'S LAST NAME

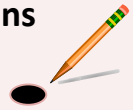
PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

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



PAST MEDICAL HISTORY

Please indicate if YOU have a history of the following:

○ **I HAVE NO MEDICAL HISTORY**

PAST	CURRENT	
○	○	Anemia
○	○	Appendicitis
○	○	Arthritis
○	○	Asthma
○	○	Bladder Infection
○	○	Cancer
○	○	Congestive Heart Failure
○	○	COPD
○	○	Deep Vein Thrombosis (DVT)
○	○	Diabetes (Type 2 Adult Onset)
○	○	Insulin Dependent
○	○	Emphysema
○	○	Esophagitis
○	○	Gallbladder Problems
○	○	Glaucoma
○	○	Head Injury
○	○	Heart Attack

PAST	CURRENT	
○	○	Heart Murmur
○	○	Heart Palpitations
○	○	Hepatitis
○	○	Hernia
○	○	High Blood Pressure
○	○	Phlebitis (Vein Swelling)
○	○	Pleurisy
○	○	Pneumonia
○	○	Rheumatic Fever
○	○	Stroke
○	○	Thyroid Problems
○	○	Tuberculosis
○	○	Ulcers
○	○	Urinary Tract Infection (UTI)
	○	HIV

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

Please make sure the ovals are filled in and not just checked. Correct: ● Incorrect: ⊗

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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ALLERGIES

Are you allergic to any drugs / medications?

- ◯ **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?

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

Please make sure the ovals are filled in and not just checked. Correct: ● Incorrect: ⊗

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 Occupation: ◯ office worker ◯ homemaker ◯ outdoor worker ◯ retired ◯ other _____

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

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

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

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

Would you like a copy of your clinical summary when you check out? ◯ yes