Do not write, stamp, punch holes or affix a sticker in this area.

To reproduce, follow the printing instructions. Do not fold this form.

Direction of Feed

Patient History

Please answer every question

STAFF: *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)

AGE

Age: _____

Parent / guardian name (if patient is under 18): _____

Height: _____

Email address: _____

Help us improve the care we deliver by providing your email address used to ask about your visit.

Are you taking, or have you ever taken, blood thinners? ◯ yes ◯ no

If you are 65 years of age or older, have you had a Pneumonia vaccine?

◯ no ◯ yes **If yes, approximately when?** _____

PAST MEDICAL HISTORY

Please indicate if YOU have a history of the following. Mark all that apply.

◯ **I HAVE NO CURRENT PROBLEMS**

◯ **I HAVE NO PAST PROBLEMS**

CURRENT	PAST		CURRENT	PAST	
◯	◯	Excessive or Prolonged Bleeding	◯	◯	High Blood Pressure
◯	◯	Blood Clots	◯	◯	Low Blood Pressure
◯	◯	Anemia	◯	◯	Circulatory Problems
◯	◯	Reaction to Anesthesia	◯	◯	Heart Disease
◯	◯	Hepatitis (specify type): ◯ A ◯ B ◯ C	◯	◯	Heart Defect
◯	◯	Kidney Disease	◯	◯	Stroke
◯	◯	Dialysis	◯	◯	Epilepsy
◯	◯	Arthritis	◯	◯	HIV / AIDS
◯	◯	Rheumatoid Arthritis	◯	◯	Emphysema
◯	◯	Bone or Joint Infections	◯	◯	Lung Disease
◯	◯	Osteoporosis	◯	◯	Seizures
◯	◯	Chemical Dependency	◯	◯	Pneumonia
◯	◯	Fractures	◯	◯	Asthma
◯	◯	Joint Dislocations	◯	◯	Tuberculosis
◯	◯	Rheumatic Fever	◯	◯	Sleep Apnea
◯	◯	Thyroid Disease	◯	◯	Stomach Ulcers
◯	◯	Diabetes	◯	◯	Chemotherapy
			◯	◯	Cancer

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

_____

SOCIAL HISTORY

Do you use tobacco? ◯ never ◯ previously ◯ currently (every day) ◯ currently (some days)

Do you drink alcoholic beverages? ◯ yes ◯ no ◯ quit

ALLERGIES

Please list your reaction(s) on the write in lines. (e.g., anaphylaxis, hives, rash, itchy eyes, swelling of mouth / throat, etc.)

Are you allergic to any DRUGS / MEDICATIONS?

◯ **I HAVE NO KNOWN ALLERGIES TO MEDICATIONS**

◯ Aspirin_____

◯ Codeine_____

◯ NSAIDS (e.g., ibuprofen, naproxen) _____

◯ Morphine _____

◯ Penicillin _____

◯ Sulfa _____

Other (please specify):

_____

For technical support, please contact PatientLink at ***Support@MyPatientLink.com.***

ALLERGIES continued

Please list your reaction(s) on the write in lines.

Are you allergic to any ENVIRONMENTAL ALLERGENS?

- ◯ **I HAVE NO KNOWN ENVIRONMENTAL ALLERGIES**
- ◯ Adhesive Tape _____
- ◯ Animal Dander _____
- ◯ Bee Stings _____
- ◯ Contrast Dye _____
- ◯ Eggs _____
- ◯ Food Dye _____
- ◯ Iodine _____
- ◯ Latex _____
- ◯ Metal _____
- ◯ Mold _____
- ◯ Nuts _____
- ◯ Pollen _____
- ◯ Shellfish _____
- **Other** (please specify) _____

MEDICATIONS

Please list all medications you are currently taking.

Include prescription medications, over-the-counter medications, vitamins and herbal supplements.

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

Name	Dosage	Frequency

Name	Dosage	Frequency

FAMILY HISTORY

Please indicate which family member(s) have had these illnesses:

◯ **I HAVE NO SIGNIFICANT FAMILY HISTORY**

	Father	Mother	Grandmother *Mother's side*	Grandfather *Mother's side*	Grandmother *Father's side*	Grandfather *Father's side*	Brother	Sister
Diabetes	◯	◯	◯	◯	◯	◯	◯	◯
Blood / Clotting Disorders	◯	◯	◯	◯	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯	◯	◯	◯	◯
Rheumatoid Arthritis	◯	◯	◯	◯	◯	◯	◯	◯
Difficulty with Anesthesia	◯	◯	◯	◯	◯	◯	◯	◯

SURGICAL HISTORY

Please indicate if YOU have had any of the following surgeries. Mark all that apply.

◯ **I HAVE HAD NO SURGERIES**

- ◯ Aneurysm Repair
- ◯ Appendectomy
- ◯ Coronary Artery Bypass
- ◯ Gallbladder
- ◯ Gastric
- ◯ Heart Stent
- ◯ Hernia Repair
- ◯ Hysterectomy
- ◯ Lung
- ◯ Pacemaker
- ◯ Thyroidectomy
- ◯ Tonsillectomy

neck	low back	
◯	◯	Spinal Decompression
◯	◯	Spinal Fusion
◯	◯	Disc Surgery

left	right	both	
◯	◯	◯	Arthroscopic Knee
◯	◯	◯	Total Knee Replacement
◯	◯	◯	Partial Knee Replacement
◯	◯	◯	Carpal Tunnel Release
◯	◯	◯	Rotator Cuff Repair
◯	◯	◯	Arthroscopic Shoulder
◯	◯	◯	Total Shoulder
◯	◯	◯	Hip Fracture Repair
◯	◯	◯	Total Hip Replacement
◯	◯	◯	Partial Hip Replacement
◯	◯	◯	Ankle Surgery
◯	◯	◯	Foot Surgery

Other Surgery (please specify):

_____