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

SOCIAL HISTORY

Marital status: ◯ single ◯ married ◯ divorced ◯ separated ◯ widow/er

What is your occupation? _____

Who are you living with? (Mark all that apply.)

◯ alone ◯ parents ◯ siblings ◯ nursing home
◯ spouse / partner ◯ children ◯ friends ◯ retirement community

What is your primary language?

◯ English ◯ Spanish ◯ Other (please specify): _____

What best describes your race?

◯ American Indian / Alaska Native
◯ Asian
◯ Black / African American
◯ Hispanic / Latino
◯ Native Hawaiian / Other Pacific Islander
◯ White
◯ Decline to state
◯ Other (please specify): _____
◯ Undetermined

How would you describe your ethnicity?

◯ Hispanic / Latino
◯ Not Hispanic / Latino
◯ Other (please specify): _____
◯ Undetermined

EXERCISE

Do you exercise? ◯ yes ◯ no

If yes, how often? ◯ 1-3 times per week ◯ 3-6 times per week ◯ daily

TOBACCO USE

What is your smoking status?

◯ current (some days) ◯ previous ◯ current status unknown
◯ current (every day) ◯ never ◯ unknown if ever smoked

How many packs of cigarettes do you (or did you) **smoke daily?**

◯ none ◯ <½ ◯ ½ ◯ 1 ◯ 1 ½ ◯ 2 ◯ >2

Do you chew tobacco?

◯ never ◯ previous ◯ current (some days) ◯ current (every day)

Are you exposed to passive (secondhand) **smoke?**

◯ yes ◯ yes, outdoors only ◯ no

ALCOHOL USE

Do you drink alcoholic beverages? ◯ yes ◯ no

If yes, how often?

◯ drink socially, having <1 drink per day ◯ rarely ◯ weekly ◯ daily

DRUG USE

Do you use recreational drugs? ◯ yes ◯ no

ALLERGIES

Please indicate if you are allergic to any of the following:

◯ I HAVE NO KNOWN ALLERGIES
◯ Penicillin
◯ Sulfa
◯ Codeine
◯ Novocaine
◯ Aspirin
◯ Tetanus
◯ Iodine (By Mouth)
◯ Iodine (Topical)
◯ Iodine (Intravenous)
◯ Narcotics
◯ Antibiotics
◯ Shellfish / Seafood
◯ Latex / Rubber
◯ Pain Remedies
◯ Herbs
◯ Vitamins
◯ Food Allergies
◯ Metals
◯ Other (please specify):

_____
_____
_____

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MEDICATIONS

Please list all medications, vitamins and herbal supplements you are currently taking:

◯ I AM CURRENTLY TAKING NO MEDICATIONS

Name of Medication	Dosage	Frequency

Name of Medication	Dosage	Frequency

Preferred Pharmacy (please include name and location): _____

CANCER HISTORY

Please indicate if you have had any of the following cancers. (If none, mark "**NONE**.")

- ◯ Brain
- ◯ Breast
- ◯ Colon / Rectal
- ◯ Liver
- ◯ Lung
- ◯ Ovarian
- ◯ Prostate
- ◯ Skin
- ◯ Stomach
- ◯ Other (please specify): _____
- ◯ **NONE**

MEDICAL HISTORY

Please indicate if you have a history of any of the following. (If none, mark "**NONE**.")

- ◯ Anemia
- ◯ Arthritis
- ◯ Anesthesia Problems
- ◯ Asthma
- ◯ Birth Defect
- ◯ Bleeding Disease
- ◯ Blood Clots
- ◯ Bruise Easily
- ◯ COPD / Emphysema
- ◯ Depression
- ◯ Diabetes
- ◯ Fibromyalgia
- ◯ GERD / Heartburn
- ◯ Heart Disease / Heart Attack
- ◯ Hepatitis A
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ High Blood Pressure
- ◯ HIV / AIDS
- ◯ Kidney Disease
- ◯ Lupus
- ◯ Mitral Valve Prolapse
- ◯ MRSA
- ◯ Osteoporosis
- ◯ Polio
- ◯ Reflux
- ◯ Rheumatoid Arthritis
- ◯ Seizure Disorder
- ◯ Sexually Transmitted Diseases
- ◯ Stomach Ulcers
- ◯ Stroke
- ◯ Thyroid Disease
- ◯ Tuberculosis (TB)
- ◯ Other Connective Tissue Disorder
- ◯ Other (please specify): _____
- ◯ **NONE**

FAMILY HISTORY

Please indicate if your PARENTS or GRANDPARENTS have had any of the following:

- ◯ **FAMILY HISTORY UNKNOWN / ADOPTED**
- ◯ Arthritis
- ◯ Anesthesia Problems
- ◯ Bleeding Disease
- ◯ Cancer
- ◯ Diabetes
- ◯ Heart Disease
- ◯ Hypertension (High Blood Pressure)
- ◯ Thyroid Problems
- ◯ Other (please specify): _____
- ◯ **NONE**

SURGICAL HISTORY

Please indicate if you have a pacemaker, hearing aid, or metal in your body.
(If you have none of these, mark "NONE.")

- ◯ Pacemaker
- ◯ Hearing Aid
- ◯ Metal (please specify location):

_____

- ◯ NONE

Please indicate if you have had any of the following surgeries:

◯ I HAVE HAD NO SURGERIES

- ◯ Appendectomy
- ◯ Carotid Artery
- ◯ Cesarean Section
- ◯ Colon Removal
- ◯ D&C
- ◯ Gallbladder
- ◯ Heart Bypass
- ◯ Heart Valve Replacement
- ◯ Hemorrhoidectomy
- ◯ Hernia
- ◯ Hysterectomy
- ◯ Leg Circulation
- ◯ Lower Back Disc
- ◯ Neck Disc
- ◯ Ovary Removal
- ◯ Prostate
- ◯ Sinus
- ◯ Thyroid
- ◯ Tonsillectomy
- ◯ Tubal Ligation
- ◯ Ulcer
- ◯ Vasectomy

Rotator Cuff Repair	◯ left	◯ right	◯ both
Arthroscopic Shoulder	◯ left	◯ right	◯ both
Hip Fracture	◯ left	◯ right	◯ both
Total Hip Replacement	◯ left	◯ right	◯ both
Total Knee Replacement	◯ left	◯ right	◯ both
Arthroscopic Knee	◯ left	◯ right	◯ both
Hand	◯ left	◯ right	◯ both
Ulnar Nerve	◯ left	◯ right	◯ both
Carpal Tunnel	◯ left	◯ right	◯ both
Foot	◯ left	◯ right	◯ both
Spinal Fusion	◯ neck	◯ lower back	
Spinal Decompression	◯ neck	◯ lower back	
Kidney Removal	◯ left	◯ right	◯ both
Cataract	◯ left	◯ right	◯ both
Breast Cancer Lump Removal	◯ left	◯ right	◯ both
Mastectomy	◯ left	◯ right	◯ both
Breast Reconstruction	◯ left	◯ right	◯ both
Breast Biopsy	◯ left	◯ right	◯ both
Other Breast Surgery	◯ left	◯ right	◯ both
Lung	◯ left	◯ right	◯ both

◯ **Other** (please specify): _____