HEALTH HISTORY

Patient Name_____Age_____Family doctor_____

Allergic to any medications? Please list medication & reaction:_____
_____
_____
Allergic to latex ?_____reaction_____Allergic to Seafood/Iodine?_____reaction_____

Have you ever had problems with anesthesia?____explain_____
_____

What is your preferred pharmacy? Name and location_____

Current Prescription Medications, Vitamins and supplements; including dose & frequency__________
_____
_____
_____
_____
Aspirin/Ibuprofen/Tylenol/Other_____

Please list *all* previous surgeries

Brain_____ Eyes_____
Thyroid/Parathyroid_____ Bladder_____
Tonsils_____ Breast_____
Heart_____ Lung_____
Liver/Gallbladder_____ Appendix_____
Esophagus/stomach_____ Kidney_____
Colon/Small bowel_____ Rectum, Anus_____
Spine_____ Arms/Legs/Joints_____
Uterus/Ovaries_____ Prostate_____
Skin_____ Hernia, type_____
Other_____

Other serious injuries:_____
_____

Medical History-*please check all that apply*

General:	Chronic fever_____ Excessive weight loss_____ Other_____
Eyes:	Glasses____ Cataracts____Glaucoma____Vision loss____Other_____
Ear/nose/throat:	Hearing loss____Seasonal allergies____Sinus infections_____Dentures_____
	Swallowing problems____Reflux_____Hoarseness____Other_____
Heart:	Heart attack____ Heart murmur____High blood pressure____Angina____
	Palpitations____Atrial fibrillation____Pacemaker____CHF____CAD_____
Lungs:	Asthma____Shortness of breath____Sleep Apnea____COPD_____
	Chronic cough____Home oxygen____Other_____
Gastric/bowel:	Nausea/vomiting____Pain____Change in stool_____Ulcer____IBS_____Crohns's_____
	Rectal bleeding____Hemorrhoids____Jaundice/Hepatitis____Other_____
Skin:	Melanoma____Other skin cancers_____Keloids____Other_____
Muscle/bone:	Back pain____Joint pain____Sciatica____Slipped disc____Other_____
Nerve:	Stroke____Seizures____Blackouts____Migraines____Polio____Parkinson's__ _____
Psych:	Anxiety____Depression____Phobias____Sleeping pills____Other_____
Endocrine:	Diabetes____Thyroid: hypo/hyper____Cholesterol____Other_____

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Hematologic: Anemia____Mononucleosis____Clotting disorder_____Other_____
Immune: Steroids____Autoimmune_____Arthritis____HIV____Other_____
Urinary: Kidney Stones____UTI's____Frequency/Urgency____Retention____Other_____
Male: Prostate problems____BPH_____Testicular problems____Other_____
GYN: Menopause_____Pregnancies_____
Ovarian cysts_____Fibroids_____Other_____
Cancer: Type of cancer_____treatment_____

Social history: Occupation:_____
Current tobacco use: what type_____ how much/low long_____
Past tobacco use: what type_____how much/how long_____year quit_____
Current alcohol use: how much/how often_____
Past history of alcohol use:_____year quit_____
Recreational drugs_____how much/howoften_____quit____

Please list any specialists you have seen in the past 5 years, for example: heart, lung, oncology, GI, OB/GYN, etc.:
_____
_____
_____

Please list any recent hospitalizations:_____
_____
_____

Please list any recent medical tests/procedures including when & where they were done
Labwork:_____
xrays:_____
procedures(scope, biopsy, etc):_____

Please list any ongoing treatment such as dialysis, chemotherapy, radiation, infusions, injections, etc:
_____

Family history (*please circle alive or deceased)*
Father: alive or deceased--Birthyear_____Medical history_____
Mother: alive or deceased Birthyear_____Medical history_____
Sibling medical history:_____
_____
_____
Other significant family medical history_____
_____

Patient signature_____Date_____