

## PATIENT HISTORY FORM

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**DRUG ALLERGIES:** \_\_\_\_\_

### Current Medications

Medications	Dose	Reason For Medication

### Past Medical History

Surgeries/Hospitalizations	Year	Physician	Hospital

### Family History

Member	Alive	Deceased	Health Status or Cause of Death
Father	A	D	
Mother	A	D	
Sister/Brother	A	D	
Sister/Brother	A	D	
Sister/Brother	A	D	

**Patient History Form**  
**Continued**

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Review of Systems**

Are you currently having or have you had problems with :

	<b>Circle</b>		<b>Describe all Yes responses</b>
Eyes	No	Yes	_____
Ears, Nose, Throat	No	Yes	_____
Lungs, Breathing	No	Yes	_____
Digestion	No	Yes	_____
Bowel Movement	No	Yes	_____
Bladder Problem	No	Yes	_____
Diabetes	No	Yes	_____
High Blood Pressure	No	Yes	_____
Bleeding Problems	No	Yes	_____
Balance Problems	No	Yes	_____
Numbness/Tingling	No	Yes	_____
Blackout/Fainting	No	Yes	_____
Psychological Problems	No	Yes	_____
AIDS	No	Yes	_____
Cancer	No	Yes	_____
Arthritis	No	Yes	_____
Polio	No	Yes	_____
TB	No	Yes	_____
Epilepsy	No	Yes	_____

Have you ever had general anesthesia? No Yes

Have any problems with anesthesia? No Yes If yes, describe: \_\_\_\_\_

**Social History**

Work in the home     Employed (occupation \_\_\_\_\_)     Student     Retired     Daycare

Single     Married     Divorced     Separated     Widowed

Exercise?     Daily     Monthly     Rarely     Never

What type of exercise (if applicable): \_\_\_\_\_

History of substance abuse?     No     Yes    If Yes, what? \_\_\_\_\_

Smoke currently?     No     Yes    \_\_\_\_\_ Packs per day for \_\_\_\_\_ years.

Quit Smoking?     This year     >1 year     >5 years     >10 years

Previously smoked    \_\_\_\_\_ packs per day for \_\_\_\_\_ years.

Drink alcohol?     Daily     1-2 x/week     1-2 x/month     1-2 x/year

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_