

# PATIENT HISTORY

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

DOB: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ What brought you in today? \_\_\_\_\_

## PAST MEDICAL HISTORY

Do you now or have you ever had:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Sleep apnea         | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Jaundice              |
| <input type="checkbox"/> Heart disease            | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Mental illness        |
| <input type="checkbox"/> Heart attack             | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Jaundice              |
| <input type="checkbox"/> Heart valve problems     | <input type="checkbox"/> Urinary problems    | <input type="checkbox"/> Bleeding problems     |
| <input type="checkbox"/> Abnormal heart rhythm    | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Problems w/Anesthesia |
| <input type="checkbox"/> Pacemaker/internal defib | <input type="checkbox"/> Epilepsy (seizures) |  |
| <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Hepatitis           |  |
| <input type="checkbox"/> Poor circulation to legs | <input type="checkbox"/> Blood clot/DVT      |  |
| <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Anemia              |  |

Other medical conditions (please list):

Past surgical history: \_\_\_\_\_

Drug use? Y/N If yes, when did you start/quit? \_\_\_\_\_

Do you smoke? Y/N If yes, when did you start/quit? \_\_\_\_\_ How much do you smoke? \_\_\_\_\_

Do you drink alcohol? Y/N If yes, frequency? \_\_\_\_\_ If no, when did you quit? \_\_\_\_\_

## CURRENT MEDICATIONS

Drug allergies:  No  Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements: Name of drug, dose(include strength & number of pills per day) and how long you have been taking it.

1.

2.

3.

4.

Pharmacy name/phone-

## FAMILY HISTORY

### Any blood relatives have?

#### Diabetes

- Mother/Father
- Siblings
- Grandparents

#### High Blood Pressure

- Mother/Father
- Siblings
- Grandparents

#### Heart Disease

- Mother/Father
- Siblings
- Grandparents

#### Abdominal Aortic Aneurysm

- Mother/Father
- Siblings
- Grandparents

#### Stroke

- Mother/Father
- Siblings
- Grandparents

#### Poor Circulation

- Mother/Father
- Siblings
- Grandparents