PATIENT HISTORY

Patient Name:_____ DOB:_____

Height:_____ Weight:_____What brought you in today?_____

PAST MEDICAL HISTORY		
Do you now or have you ever had:		
❑ Diabetes	❑ Sleep apnea	❑ Seizures
❑ High blood pressure	❑ Kidney disease	❑ Jaundice
❑ Heart disease	❑ Asthma	❑ Mental illness
❑ Heart attack	❑ HIV/AIDS	❑ Jaundice
❑ Heart valve problems	❑ Urinary problems	❑ Bleeding problems
❑ Abnormal heart rhythm	❑ Cancer	❑ Problems w/Anesthesia
❑ Pacemaker/internal defib	❑ Epilepsy (seizures)	
❑ Stroke	❑ Hepatitis	
❑ Poor circulation to legs	❑ Blood clot/DVT	
❑ Emphysema	❑ 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	**High Blood Pressure**	**Heart Disease**
❑ Mother/Father	❑ Mother/Father	❑ Mother/Father
❑ Siblings	❑ Siblings	❑ Siblings
❑ Grandparents	❑ Grandparents	❑ Grandparents
Abdominal Aortic Aneurysm	**Stroke**	**Poor Circulation**
❑ Mother/Father	❑ Mother/Father	❑ Mother/Father
❑ Siblings	❑ Siblings	❑ Siblings
❑ Grandparents	❑ Grandparents	❑ Grandparents