# 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 |
| 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 |