

**PATIENT MEDICAL HISTORY**

*CONFIDENTIAL INFORMATION:* information contained herein will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information that you provide will be used by your doctor in decisions regarding your care.

**Patient Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

**Physician Information**

Referring Physician: \_\_\_\_\_ Address: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Address: \_\_\_\_\_

**Medical Information**

Reason for visit: \_\_\_\_\_

If this is for a medical reason, list date of onset: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Do you currently have, or have you ever had any of the following? (Please circle – if “yes”, give date of onset/occurrence)

- |                         |              |                     |              |
|-------------------------|--------------|---------------------|--------------|
| AIDS or HIV+            | No Yes _____ | Heart Condition     | No Yes _____ |
| Anxiety                 | No Yes _____ | Hepatitis           | No Yes _____ |
| Arthritis               | No Yes _____ | High blood pressure | No Yes _____ |
| Asthma                  | No Yes _____ | Kidney disease      | No Yes _____ |
| Back Problems           | No Yes _____ | Migraines           | No Yes _____ |
| Bleeding disorder       | No Yes _____ | Seizure Disorder    | No Yes _____ |
| Blood clotting disorder | No Yes _____ | Stomach ulcers      | No Yes _____ |
| Cancer                  | No Yes _____ | Stroke              | No Yes _____ |
| Colitis                 | No Yes _____ | Thyroid disorder    | No Yes _____ |
| Depression              | No Yes _____ | Tuberculosis        | No Yes _____ |
| Diabetes                | No Yes _____ | Weight loss/gain    | No Yes _____ |
| Heart attack            | No Yes _____ |                     |              |

Other serious medical conditions that you have or have had, not mentioned above:  
 \_\_\_\_\_

Have you ever had surgery? (If “yes”, please list the name of the operation and the date it was performed):  
 \_\_\_\_\_

Other serious illnesses or injuries that you have had, not mentioned above:  
 \_\_\_\_\_

Have you ever had any complications from anesthesia? (If “yes”, please explain):  
 \_\_\_\_\_

## Social History

**Do you currently smoke?** Yes No

If "yes": How much? \_\_\_\_\_ If "no": Have you ever smoked? Yes No If "yes": When did you quit? \_\_\_\_\_

**Do you regularly drink alcohol?** Yes No If "yes": How much? \_\_\_\_\_ How often? \_\_\_\_\_

Do you have any known allergies to medications, iodine/contrast dye, or LATEX? Yes No

If "yes", please list: \_\_\_\_\_

### **For women only:**

Is there a chance you might be pregnant? Yes No

Are you still having regular monthly menstrual periods? Yes No Date of last period? \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_ Results: \_\_\_\_\_

How many children do you have? \_\_\_\_\_

*We recommend routine breast and pelvic exams by your physician for all adult females.*

**Are you presently taking any of the following medications?** (If "yes", please circle and list the name of the medication).

Accutane (Isotretinoin) \_\_\_\_\_ Hormones \_\_\_\_\_

Antibiotics \_\_\_\_\_ Insulin or diabetic pills \_\_\_\_\_

Anxiety/Depression Meds \_\_\_\_\_ Laxatives \_\_\_\_\_

Arthritis medicine \_\_\_\_\_ Retin-A \_\_\_\_\_

Aspirin, Bufferin, Anacin \_\_\_\_\_ Seizure Meds \_\_\_\_\_

Birth control pills \_\_\_\_\_ Sleeping pills \_\_\_\_\_

Blood pressure pills \_\_\_\_\_ Steroids \_\_\_\_\_

Blood thinning pills \_\_\_\_\_ St. Johns Wart \_\_\_\_\_

Cough medicine \_\_\_\_\_ Thyroid medicine \_\_\_\_\_

Digitalis \_\_\_\_\_ Water pills \_\_\_\_\_

Headache meds \_\_\_\_\_ Weight reducing pills \_\_\_\_\_

Herbal Supplement \_\_\_\_\_

Other vitamins, supplements, or medications not listed above: \_\_\_\_\_

## Family Medical History

If a blood relative has/had any of the following conditions, please circle and give relationship (blood relatives includes siblings, parents, grandparents, children):

Bleeding tendency \_\_\_\_\_ Heart disease \_\_\_\_\_

Blood clotting disorder \_\_\_\_\_ Diabetes \_\_\_\_\_

Breast cancer \_\_\_\_\_ Stroke \_\_\_\_\_

Please list anything about yourself or your health that you think would be important for the doctor to know: \_\_\_\_\_