PATIENT HISTORY

PATIENT NAME: _____ **DATE:** _____

AGE: _____ **BIRTHDATE:** _____ **SEX: M F** **HEIGHT:** _____ **WEIGHT:** _____

WHAT IS THE NAME OF YOUR FAMILY PHYSICIAN? _____

Are you allergic or sensitive to any medications, including pain medications? **YES** **NO**

Medication	Reaction	Medication	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any kind of tape? **YES** **NO** **Are you allergic to latex?** **YES** **NO**

Have you ever had a reaction to a local or general anesthesia? **YES** **NO** **If yes, please explain:** _____

_____

What conditions, if any, are you currently being treated for by a physician? _____

_____

List all medications you are now taking (including vitamins, birth control, aspirin, etc.)

_____ _____ _____ _____

_____ _____ _____ _____

Do you bruise easily or have problems with excessive bleeding? **YES** **NO**

Has any member of your family had problems with excessive bleeding? **YES** **NO**

If you answered yes to either of the last two questions, please explain: _____

_____

Do you wear: □ **contact lenses** □ **eye glasses** □ **false teeth** □ **hearing aid**

PREVIOUS SURGERIES: Use other side of this form if more space is needed)

Operation	Year	Physician	Anesthesia (local or general)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Where there any complications and/or problems after any of the above operations? **YES** **NO** **If yes, please explain:** _____

_____

Have you ever received a transfusion? **YES** **NO** **If yes, what year?** _____

Have you been tested for HIV? **YES** **NO** **If yes, what year?**_____ **Test results:** □ **positive** □ **negative**

Have you been treated for any serious illnesses or injuries? **YES** **NO** **If yes, please explain:** _____

_____

Do you have hepatitis? **YES** **NO** **Type** **A** **B** **C** **Other:** _____

History of fainting?YES **NO** **if so, what year:** _____ **How many times?** _____

CHILDHOOD DISEASES: **(Check all that apply)**

□ **Scarlet Fever** □ **Rheumatic Fever** □ **Polio** □ **Measles** □ **Mumps** □ **Chicken Pox** □ **Whooping Cough**

FAMILY HISTORY:

Member	Age	Condition of Health	Has Any Relative Ever Had:	
Mother	_____	_____	□ Tuberculosis	□ Cancer
Father	_____	_____	□ Lung Disease	□ Kidney
Sister	_____	_____	□ Heart Disease	□ Diabetes
Brother	_____	_____	□ High Blood Pressure	□ Epilepsy

SOCIAL HISTORY: Religion: _____

What is your approximate daily consumption of each of the following:

Alcohol _____ **Tobacco** _____ **Coffee/Tea/Cola** _____

WOMEN PATIENTS ONLY:

Number of pregnancies: _____ **Number of Children:** _____ **Did you breast feed?** **YES** **NO**

If so, for how long? _____ **Have you ever had a mammogram?** **YES** **NO** **Date:** _____

Are you pregnant now? **YES** **NO** **Last PAP test date:** _____ **Date of your last period:** _____