

PATIENT HEALTH HISTORY FORM

Information contained here will be treated in a confidential manner and not released without your authorization. Please take the time to answer all appropriate questions to the best of your knowledge, as this information is important to your doctor in his decisions regarding your care.

Date: _____ Name: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ Ideal Weight: _____ Sex: _____ Marital Status: _____

Referred By: _____ Personal Physicians: _____

Employment: _____

MEDICATIONS	Yes	No		Yes	No		Yes	No
Pain Medication	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone/Steroids	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Blood Thinners	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss Pills	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>

List all names of meds (with amounts and how often) taken: _____

MEDICATION ALLERGIES / SENSITIVITIES	Yes	No		Yes	No		Yes	No
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>			

List reactions which have occurred for each above "Yes" response: _____

SURGICAL HISTORY

List all previous operations, dates and any complications:

Date	Age	Operation	Physician/Hospital	Complications
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you pregnant? Yes No How many pregnancies have you had? _____ Did you breast feed? Yes No

Date/Result Last Mammogram: _____

MEDICAL HISTORY	Yes	No		Yes	No		Yes	No
Bleeding Problems/Anemia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>
Anesthesia Problems	<input type="checkbox"/>	<input type="checkbox"/>	Herpes/Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Disease	<input type="checkbox"/>	<input type="checkbox"/>
Scarring Problems	<input type="checkbox"/>	<input type="checkbox"/>	Breast Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>						

Explain and give dates for each of the above "Yes" responses: _____

Do you use alcohol? No Yes Light Heavy

Do you Smoke: Yes No Avg. # packs a day: _____ # of years _____ Date Quit: _____

FAMILY HISTORY	Yes	No		Yes	No		Yes	No
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	High Fever from Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Anesthesia Problems	<input type="checkbox"/>	<input type="checkbox"/>	Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>			

List family members and explanation if necessary for each above "Yes" response: _____

Patient Signature: _____ Physician Signature: _____