PATIENT HISTORY FORM

To the patient or his representative: This form is intended to aid your attending physician in evaluating your past medical history. Please answer all appropriate questions as briefly as possible. This form is confidential and information given will become a part of the permanent medical record. Please complete as soon as possible and give to your attending physician.

_____

MEDICAL:	**YES**	**NO**		**YES**	**NO**
Measles	___	___	Mastitis	___	___
Mumps	___	___	Migraine	___	___
Chickenpox	___	___	Headache	___	___
Whooping Cough	___	___	Ear Infections	___	___
Rheumatic Fever	___	___	Strep Throat	___	___
Pleurisy	___	___	Tonsillitis	___	___
Pneumonia	___	___	Thyroid Disorder	___	___
Gallstones	___	___	Bronchitis	___	___
Diabetes	___	___	Emphysema	___	___
Heart Attack	___	___	Kidney Infection	___	___
Heart Disease	___	___	Prostate Infection	___	___
Epilepsy	___	___	Stomach Ulcers	___	___
Arthritis	___	___	Varicose Veins	___	___
High Blood Pressure	___	___	Tuberculosis	___	___
Strokes/Paralysis	___	___	Cancer	___	___
Hemorrhoids	___	___	Hypoglycemia	___	___
Blood Transfusions	___	___	(Low Blood Sugar)		

Other:

_____
_____
_____

SURGERY:	**YES**	**NO**		**YES**	**NO**
Tonsillectomy	___	___	Hysterectomy	___	___
Adenoidectomy	___	___	Appendectomy	___	___
Thyroid Surgery	___	___	Hemorrhoid	___	___
Gallbladder	___	___	Surgery		
Removal			Hernia Repair	___	___
Breast Biopsy or			Removal of Any		
Removal	___	___	Skin Tumor	___	___

FAMILY HISTORY:

FATHER: Living _____ Age _____

Dead _____ Age _____

If living, state of health_____

_____

If dead, cause of death_____

_____

BROTHERS AND SISTERS:

Name	**Living**	**Dead**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT'S NAME _____ AGE _____

TELEPHONE # _____

ATTENDING PHYSICIAN _____

DATE OF BIRTH _____

_____

ALLERGIES:

DRUGS	**YES**	**NO**	**NEVER TAKEN**
Penicillin	____	___	_____
Sulfa Drugs	____	___	_____
Aspirin	____	___	_____
Keflex	____	___	_____
Codeine	____	___	_____
Morphine	____	___	_____
Tetanus	____	___	_____

Other Drugs (List)

_____
_____
_____

Food Allergies (List)

_____
_____
_____

TRAUMA/INJURIES:	YES	NO
Cerebral (Brain) (Concussion)	____	____
Fractures (Broken Bones)	____	____

List

_____ ____ ____

_____ ____ ____

_____ ____ ____

Dislocations (Joints)

_____ ____ ____

_____ ____ ____

_____ ____ ____

Back Injury ____ ____

OB-GYN: (Females Only)

Total Pregnancies _____Total Live Births _____

Total Miscarriages _____

Onset of Menstrual Periods (Age) _____

Age at Menopause or Date of Last Period _____

Any Child Over 8 lbs at Birth: Yes _____ No _____

MOTHER: Living _____ Age _____

Dead _____ Age _____

If living, state of health _____

_____

If dead, cause of death _____

_____

State of Health or Cause of Death:

_____

_____

_____

_____

_____