

PATIENT HEALTH HISTORY

Name: _____ Date: _____ ()S ()M ()D ()W
 DOB _____ Age _____ Occupation: _____
 Emergency Contact: _____

Personal Medical History: (Please check each item as appropriate.)		Allergies:	
	Yes	No	Are you allergic to:
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Betadine <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Novocaine <input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin <input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa <input type="checkbox"/>
Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin <input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Codeine <input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Injuries:
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Have you had:
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Concussion <input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury <input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Car Accident Injury <input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Consciousness <input type="checkbox"/>
Gall Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	Surgical History:
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Have you had:
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy <input type="checkbox"/> Yes <input type="checkbox"/> No
Urinary Infection	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy <input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Hernia Operation <input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Operation <input type="checkbox"/>
Nervous or Mental Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart Operation <input type="checkbox"/>
Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	Facial Surgery <input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Oral Surgery <input type="checkbox"/>
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
Infectious Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	

Do you currently smoke? No Yes _____ pack/day currently _____ number of years.
 Have you ever smoked? No Yes _____ How long since you last smoked? _____

Do you drink alcoholic beverages? No Yes _____ number of drinks/week.

Family History:	Age	If living-list all medical conditions	Age at death	Cause of death if deceased
Father				
Mother				
Brother				
Brother				
Brother				
Sister				
Sister				
Sister				

Name of physicians that are familiar with your medical history:

