HEALTH HISTORY

Please complete the following information for review by your provider.

Name: ______________________ Birth Date: ____/____/____ Age: ______

Height: ______ Weight: ______ Race: ______ Sex: ○ M ○ F Dominant Hand: ○ Right ○ Left

Referring Doctor: ______________ Family Doctor: ______________ Occupation: ______________

Patient Medical History

○ Heart Trouble	○ Gout	○ Bleeding Problems	○ Anemia	○ AIDS/HIV
○ High Blood Pressure	○ Seizures	○ Serious Injuries	○ Stomach Ulcers	○ Hepatitis
○ Stroke	○ Sleep Apnea	○ Lung Disease	○ Liver Trouble	○ Other:
○ Diabetes	○ Kidney Trouble	○ Asthma	○ Thyroid Trouble	____________
○ Arthritis	○ Osteoporosis	○ Phlebitis	○ Cancer	____________

Previous Surgeries: ☐ *None* Hospital/Date	Previous Surgeries: Hospital/Date
1.	4.
2.	5.
3.	6.

Family Medical History (Mark if any of these run in your family)

○ Heart Trouble	○ Stroke	○ Arthritis	○ Seizures	○ Kidney Trouble	○ Alcoholism
○ High Blood Pressure	○ Diabetes	○ Gout	○ Mental Illness	○ Bleeding	○ Cancer

Social History

Married / Single Do you live alone? ○ Yes ○ No If no, who do you live with? ______________

# of children: ________ Do you exercise regularly? ○ Yes ○ No Describe: ______________

Tobacco Use? ○ Yes ○ No Type: ______________ Amount per day ________ # of years used: ____

Alcohol Consumption? ○ Yes ○ No # of drinks/week: ______ History of Alcoholism? ○ Yes ○ No

Recreational/Drug Usage: ○ Yes ○ No Type/Amount/How Often: ______________

Review of Systems *(recent or current conditions only)*

○ Weight Change	○ Ear Pain / Ringing	○ Shortness of Breath	○ Incontinence	○ Numbness
○ Fever / Chills	○ Nosebleeds	○ Cough	○ Urinary Frequency	○ Weakness
○ Night Sweats	○ Hoarseness	○ Stomach Pain	○ Urinary Burning	○ Frequent Headaches
○ Poor Appetite	○ Difficulty Swallowing	○ Nausea / Vomiting	○ Irregular Periods	○ Seizures
○ Rash	○ Tooth/Gum Trouble	○ Frequent Diarrhea	○ Vaginal Discharge	○ Blackouts
○ Insomnia	○ Visual Changes	○ Frequent Constipation	○ Pregnant	○ Chronic Infection
○ Depression	○ Chest Pain	○ Blood in Stool	○ Joint/Limb Swelling	○ ____________
○ Anxiety	○ Abnormal Heartbeat		○ Joint Pain	
			○ Lumps/Masses	
			○ Backache	

Patient Signature: ______________________________ Date: ______________

Notes:

Physician Reviewed:
Initials: ______ Date: ________
Initials: ______ Date: ________
Initials: ______ Date: ________
Initials: ______ Date: ________

MEDICATION RECORD

Please complete the following information for review by your provider.

Name: ______________________ Birth Date: ____/____/____ Age: ________

Today's Date: ____________________

Allergies to Medications: ○ None ○ Yes, list →

Latex Allergy/Sensitivity? ○ Yes ○ No

Metal Allergy? ○ Yes ○ No

List any food allergies and reaction: ☐ *None*

Medication	Allergic Reaction

Medications you currently take (including over the counter medications, vitamins, herbs, & prescribed drugs):

☐ See separate medication list

Date	Medication	Dosage/Frequency	*For Surgery Center Use Only*

8/17/11 sks

Provider Reviewed:

Initials: ______ Date: ________ Time: ________
Initials: ______ Date: ________ Time: ________
Initials: ______ Date: ________ Time: ________
Initials: ______ Date: ________ Time: ________

Patient Label