MEDICAL HISTORY

INFORMATION IS STRICTLY CONFIDENTIAL. Please answer all questions completely, and to the best of your knowledge, to enable the doctor to make proper medical decisions.

LAST NAME________________________________ FIRST_________________________ AGE ________ SEX ________

HEIGHT _________ WEIGHT _________ RIGHT/LEFT HANDED _______ RELIGION______________________________
OPTIONAL

OCCUPATION____________________________ REFERRED BY ____

SURGERIES

Breast Biopsy

Breast Surgery (**list type & date**)

____

____

____

Abdominal Surgery (**list type & date**)

____

____

Other (**list type & date) ____**_________

____

____

____

Anesthesia Problems (list type)

____

FAMILY HISTORY
(if yes, list relation)**

Cancer

Heart Problems

High Blood Pressure

Blood Disease

Lung Problems

Circulation Problems

Diabetes

Stroke

Drug or Alcohol Abuse

Anesthesia Problems

FOR WOMEN

Pregnancies_______ # Deliveries_______

Contraception Type___________________

Date of last mammogram _____________

Result__________________

Bra Size_________________ (*optional)
*breast surgery patients required to answer

MEDICAL CONDITIONS

High Blood Pressure

Heart Murmur

Coronary Artery Disease

Heart Failure

Arrythmia

Cholesterol

Lung Problems

Cancer

Arthritis

Intestinal Problems

Thyroid Problems

Emphysema/Chronic Bronchitis

Asthma

Diabetes

Kidney Problems

Stroke

Circulation Problems

Vericose Veins

TB

HIV

Liver Disease

Hepatitis

Blood Clots

Bleeding Tendencies

Sleep Apnea

Psychological

Drug Abuse

Seizure

Chronic Back Pain

Wound Healing Issues

Easy Bruising

Other: ________________________

____

____

ADVANCED DIRECTIVE
(for patients **over 65**)
Do you have a surrogate decision maker?

YES

NO

LIST ALL FOOD & DRUG ALLERGIES ALONG WITH REACTION

____

____

____

____

____

MEDICATIONS (list dose and frequency)
Include supplements.

____

____

____

____

____

____

____

____

PREFERRED PHARMACY

____
NAME & LOCATION **(CITY & CROSSROADS)**

SMOKING

No, never smoked

Yes, but I quit as of ________________

Yes, I currently smoke ________packs per day for (#) of years ________

ALCOHOL Did you have a drink containing alcohol in the past year?

No

Yes

If yes, how often?:

1 or less a month

2-4 times per month

2-3 times a week

4 or more times a week

Average # of drinks per occurrence:_______

Race ________________ Ethnicity ________________ Language ____________________ ❑ DO NOT WISH TO REPORT

____ ______________________
PATIENT SIGNATURE (OR RESPONSIBLE PARTY IF MINOR) **DATE**