



Patient Health History

Date: ___/___/___

Name _____ Date of Birth ___/___/___ Age: ___
 Last First Middle Initial Maiden Month Day Year Sex: F M
 Height: ___ Weight: ___ Shoe Size ___ Primary Language: _____ Do you need an interpreter? _____

Past Medical History

In the past 2 weeks, have you had a cough, cold, sore throat or bronchitis that required treatment? _____

Do you now or have you ever had any of the following? (If yes, check box)

- | | | | | |
|--|---|------------------------------------|---|--|
| <input type="checkbox"/> Cancer Type: _____ | <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Raynaud's Disease | <input type="checkbox"/> Leukemia | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> COPD | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> MRSA | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Back Problems |

List any other conditions you have had that are not already noted _____

Do you have any implants? Cosmetic Pacemaker Orthopedic Dental Other _____

Drug Allergies: Yes No To What? _____ Type of Reaction: _____

Current Medications (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication?	Please check: Meds helped?		
			A lot	Some	Not at all
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you used blood thinners, such as Coumadin, Heparin, Aspirin, Ibuprofen, Aleve, or Plavix, within the past 2 weeks? _____

Have you ever taken steroids, such as Prednisone or Medrol, by mouth? _____ If yes, when and for how long? _____

Do you take medication for Osteoporosis such as Fosamax, Actonel, or Boniva? _____

Date of last EKG ___/___/___ Date of last Blood draw ___/___/___ Date of last Chest X-ray ___/___/___

List All Surgeries	Year	Reason
1		
2		
3		
4		
5		

Patient's Name: _____ Date Reviewed: _____ Physician Initials: _____