

NAME _____

DATE _____ DOB _____

PAST HISTORY: (circle where indicated)

Illnesses: Please circle if you have had any of these problems

Rheumatic Fever	Scarlet Fever	Pneumonia	Jaundice	Cancer	Ulcers
Anemia	Arthritis	Emphysema	Diabetes	Heart Disease	Stroke
High Blood Pressure	Asthma	Tuberculosis	Seizures	High Cholesterol	
Bleeding Tendency	Parkinson's	Nervous Disorder			

Please list other (non-surgical) illnesses requiring hospitalization: _____

OPERATIONS: Please circle if you have had surgery on: tonsils appendix uterus gallbladder

Other Operations? Please date and list: _____

MEDICATION ALLERGIES: Please circle: No Medication Allergies Penicillin Sulfa Iodine

Seafood
Others? _____

SPECIAL NEEDS: Please circle: Wheelchair Bound Use a walker Stretcher

IMPLANTS OR FOREIGN BODIES: Please circle: NO YES

If yes, what kind and what year? _____

SYSTEM REVIEW: Please Circle: Heart or Lung Trouble Chest Pain Shortness of Breath Smoke

Cough Neuromuscular Problems Seizures Nervous Dizzy Spells Stroke

Depression Weight Loss Present Weight: _____ Height: _____

GI: Constipation Blood in Stool Gastric Distress Irritable Bowel

EENT: Recent Onset of Headaches Eye Problems Glaucoma

For Women Only: # of Pregnancies: _____ # of Miscarriages: _____ Vaginal Discharge: _____

Pain with Intercourse: _____ Last Menstrual Period (date or years): _____

Other: _____

FAMILY HISTORY: How many brothers &/or Sisters? _____ Any ill or Deceased? _____

Mother: Alive or Deceased (circle) Cause of death and Age: _____

Father: Alive or deceased (circle) Cause of death and Age: _____

Please circle if any blood relatives (not yourself) have had these problems:

Birth defect of kidney or Bladder Urinary Problems Cancer Diabetes

High Blood Pressure Kidney Stones Cancer of Prostate Bleeder

Other health problems? _____

SOCIAL HISTORY:

Your usual occupation: _____ Retired? YES or NO

Of Sons: _____ ages: _____ # of Daughters: _____ ages: _____

Spouse's health: _____ Spouse's occupation: _____

HABITS: Please circle:

Smoke: No / Quit: Date and Year _____

Yes /How many packs of cigarettes per day: _____ How many years? _____

Alcohol: No / Yes: Heavy Moderate Light Occasionally # shots/beers per day: _____

Recovering Alcoholic (or other drugs)? _____