

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 pack of cigarettes per day: \_\_\_\_\_ How many years? \_\_\_\_\_

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

Recovering Alcoholic (or other drugs)? \_\_\_\_\_