

Patient History Form

Patient's Name (Last) _____ (First) _____ (MI) _____ Date of Birth MM____/DD____/YYYY____

Medical Problems: Have you had (or do you have) any of the following medical problems: (check Yes or No)

<table border="0" style="width: 100%;"> <tr><td>YES</td><td>NO</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table>	YES	NO	<input type="checkbox"/>	<input type="checkbox"/>	<table border="0" style="width: 100%;"> <tr><td>YES</td><td>NO</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table>	YES	NO	<input type="checkbox"/>	<input type="checkbox"/>	<table border="0" style="width: 100%;"> <tr><td>YES</td><td>NO</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table>	YES	NO	<input type="checkbox"/>	<input type="checkbox"/>	<table border="0" style="width: 100%;"> <tr><td>YES</td><td>NO</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table>	YES	NO	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Attack <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Positive HIV or AIDS	<input type="checkbox"/> Breast Cancer <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Other Cancer <input type="checkbox"/> Abnormal PAP <input type="checkbox"/> Hepatitis or Jaundice <input type="checkbox"/> Liver/Pancreas Disease <input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Urinary Tract Infection	<input type="checkbox"/> Other Kidney Disease <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Rec'd Blood Transfusion <input type="checkbox"/> STD Other (please describe) _____ _____																

Past Surgery: Have you had any of the following operations and year of procedure

<input type="checkbox"/> Appendix - Year: _____	<input type="checkbox"/> Gall Bladder - Year: _____	<input type="checkbox"/> Lung - Year: _____	Other (please describe) _____ _____
<input type="checkbox"/> Hernia - Year: _____	<input type="checkbox"/> Heart - Year: _____	<input type="checkbox"/> Hysterectomy - Year: _____	
<input type="checkbox"/> Tonsils - Year: _____	<input type="checkbox"/> Thyroid - Year: _____	<input type="checkbox"/> Spine/Joint - Year: _____	

Patient Social History

Marital Status: Single Married Separated Divorced Widowed
 Use of Alcohol: Never Rarely Moderate Daily Previously, Quit
 Use of Tobacco: Never Previously, Quit Current Packs Per Day: _____
 Use of Drugs: **YES** **NO** Type: _____ Frequency: _____

Family Medical History

	Age	Disease	Deceased/Cause of Death
Father			
Mother			
Sibling			

In the event a procedure needs to be rescheduled, what hospital do you prefer?

Signature: _____

Date: _____