

Patient History Form

Name _____ Date _____

Have You Ever Had

- | | | | |
|----|---------------------|-----|----|
| 1 | Diabetes | Yes | No |
| 2 | High Blood Pressure | Yes | No |
| 3 | Heart Attack | Yes | No |
| 4 | Stroke | Yes | No |
| 5 | Ulcers | Yes | No |
| 6 | Diverticulosis | Yes | No |
| 7 | Heart Trouble | Yes | No |
| 8 | Heart Murmur | Yes | No |
| 9 | Asthma | Yes | No |
| 10 | Arthritis | Yes | No |
| 11 | Cancer | Yes | No |
| 12 | Seizures | Yes | No |
| 13 | Cataracts | Yes | No |
| 14 | Prostate Trouble | Yes | No |
| 15 | Headaches | Yes | No |

Medications

Allergies

Surgeries

- | | | | |
|----|-------------------|-----|----|
| 1 | Appendectomy | Yes | No |
| 2 | Tubal / Vasectomy | Yes | No |
| 3 | Hysterectomy | Yes | No |
| 4 | Gallbladder | Yes | No |
| 5 | Prostate | Yes | No |
| 6 | Heart | Yes | No |
| 7 | Breast | Yes | No |
| 8 | Hip / Knee | Yes | No |
| 9 | Hernia | Yes | No |
| 10 | Stomach | Yes | No |
| 11 | Colon | Yes | No |
| 12 | Tonsils | Yes | No |

Do You Smoke? Yes No

Have You Ever Smoked? Yes No

Packs Per Day _____

How Many Years? _____

Do You Drink? Yes No

How Much? _____

Your Occupation _____

Do Any Blood Relatives Have

- | | | | |
|----|---------------------|-----|----|
| 1 | High Blood Pressure | Yes | No |
| 2 | Heart Trouble | Yes | No |
| 3 | Stroke | Yes | No |
| 4 | Ulcers | Yes | No |
| 5 | Breast Cancer | Yes | No |
| 6 | Colon Cancer | Yes | No |
| 7 | Diabetes | Yes | No |
| 8 | Prostate Trouble | Yes | No |
| 9 | Seizures | Yes | No |
| 10 | Alzheimer's | Yes | No |
| 11 | Migraines | Yes | No |

Comments:
