PATIENT HISTORY FORM

MRN/CSN #		

Name	}			Date of Birth						
Pleas	se circle Yes fo	r each probl	em that	applies to you:						
Yes	Allergies		Yes	Depression	Yes	Stroke				
Yes	Anemia		Yes	Diabetes Mellitus	Yes	Substance Abuse				
Yes	Anxiety		Yes	Emphysema	Yes	Stomach Ulcers				
Yes	Arthritis		Yes	GERD	Yes	Thyroid Disease				
Yes	Blood Transfusi		Yes	Glaucoma	Yes	Tuberculosis				
Yes	Cancer-if Yes, ple	ease state type	Yes	Heart Attack	Yes	Heavy snoring/sleep apnea				
			Yes	Heart Murmur						
Yes	Cataracts		Yes	HIV/AIDS		FEMALES ONLY				
Yes	Coronary Artery	Disease	Yes	Kidney Disease		of last period				
Yes	Heart Failure		Yes	Meningitis		per of Pregnancies				
Yes	Clotting Disorde	er	Yes	Nerve/Muscle Disease		at Menopause				
Yes	COPD		Yes	Osteoporosis		per of Children				
Yes	Cholesterol Pro		Yes	Seizures	Histor	ry Abnormal Pap Smear				
Yes	High Blood Pres	ssure	Yes	Sickle Cell Anemia		□ Yes □ No				
Pleas	se mark the bo	x for each su	ırgery ti	hat applies to you:						
	Appendix Remo	oval		Fracture Surgery		Prostate Surgery				
	Brain Surgery			Gall Bladder Surgery		Small Intestine Surgery				
				Gastric Bypass Surgery		Spine Surgery				
	Cardiac Stent P			Hernia Repair		Tonsillectomy/Adenoidectomy				
	□ Colon Surgery			Hysterectomy		Thyroidectomy				
				☐ Total		Valve Replacement				
	☐ Ear Surgery-Ear Tubes			☐ Partial		Vascular Surgery				
		i iubes			_	- ,				
	Eye Surgery		Ш	Joint Replacement	Ц	Vasectomy				
	Other									
Pleas	se indicate you	r occupation	or job							
Pleas	se indicate you	r marital sta	tus							
	-			as they apply to you:	•					
Yes	No Alco	ohol Use	Indica	te how many drinks per	week:					
				Cans of Beer						
			1	Shots of Liquor						
				Drinks containing	0.5 oz of	alcohol				
				Glasses of Wine						
Yes	No <u>Sex</u>	ually Active,	Partne	ers 🗆 Female 🗆	Male					
Yes	No <u>Dru</u>	g Use	Comn	nent						
Yes	No <u>Tob</u>	Tobacco Use		Pack per Day Quit Date						
			Years	as a Smoker						
Yes		Tobacco,	Comn	nent						
	<u>5mc</u>	<u>okeless</u>	Amou	nt Each Day	Quit l	Date				
Yes	No <u>Caff</u>	eine Intake	Comn	nent						



PATIENT HISTORY FORM

MRN/CSN #	

Rease indicate your family history in the boxes below: Islationship Mother Father Sister Brother Daughter Son Mom's Mom's Dad's Dad's Dad's Dad's Dad Sister State Mother Father Father Mother Father	Name				Date of Birth						
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lease indicate any other Medical Problems not addressed in this form:											
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