Patient Health History

In order for us to obtain a complete medical history, it is important that you fill out this form as completely as possible. This is very important information. Please fill out every item. It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Full Name_____________________________ □ Male □ Female Date of Birth _______________

Preferred Pharmacy (with address or crossroads) ______________________________________
Primary Care Doctor ____

State in your own words why you are seeing Dr Jones. __________________________________

Are you Currently taking any Medications □Yes □ No Please list all medications with dosages

Medication Allergies Are you allergic to any medications □ Yes □ No (please specify reaction)

Have you or anyone in your family had problems with anesthesia □ Yes □ No
If Yes, please specify reaction ____

Have you had any Surgeries or Procedures □ Yes □ No
If Yes, please list

Type of Surgery	Type of Surgery

Patient Health Information

Please check if you have been diagnosed with any of the following

□ Anxiety
□ Arthritis
□ Asthma
□ Atrial Fibrillation (Irregular Heartbeat)
□ Cancer Type_______________
□ Pulmonary Disease/ COPD
□ Coronary Artery Disease (Heart Disease)
□ Depression
□ Diabetes
□ Kidney Disease
□ GERD (Reflux)
□ Hypertension (High Blood Pressure)
□ Hypercholesterolemia (High Cholesterol)
□ Hyperthyroidism (High Thyroid)
□ Hypothyroidism (Low Thyroid)
□ Seizure
□ Stroke

□ Other (Please List)____

Family History

Do you have a family history of bleeding disorders □ No □ Yes

Do you have a family history of :
□ Hearing Loss □ Allergies □ Thyroid Disease □ Cancer Type _______________
□ Problems with Anesthesia Type ________________________

Social History

Retired □ Yes □ No Occupation ___________________________________
Tobacco Use: □ Never Smoked □ Former Smoker □ Current Smoker ___ pack per day
□ Smokeless Tobacco
Alcohol Use: □ Never □ Occasional □ Daily
Drug Use: Type _________________ How Often?____________

Review of Systems: Symptoms that you have today. **Check all that apply**

Constitutional
□ Fatigue
□ Fever and Chills
□ Temperature Intolerance

Gastrointestinal
□ Abdominal Pain
□ Nausea
□ Vomiting

Endocrine
□ Lightheadedness
□ Excessive Sweating
□ Increased Thirst

Eye
□ Double Vision
□ Loss of Vision
□ Sensitivity to Light

Musculoskeletal
□ Cramping
□ Muscle Tenderness
□ Weakness

Hematological
□ Excessive Bleeding with Injury
□ Persistent Swelling in Limbs
□ Aspirin Use

Cardiovascular
□ Blacking out or Fainting
□ Chest Pain
□ Heart Murmur

Integumentary
□ Easy Bruising
□ Poor Wound Healing
□ Rash

Immunological
□ Unusual Infection
□ Multiple Tender Lumps under Skin
□ Rash When Exposed to Sun

Respiratory
□ Chest Pain or Tightness
□ Shortness of Breath
□ Wheezing

Neurological
□ Changes of vision
□ Numbness
□ Paralysis