CONFIDENTIAL MEDICAL HISTORY

Patient Name: ____
Please answer ALL questions. If you do not know the answer, or do not understand the question, insert a ? in the space.

Nature of complaints: ____

GENERAL HEALTH

Do you smoke? ____ How many packs a day? ____ For how long? _____ Year quit ____
Alcoholic beverages per day: ______________ Coffee/Tea per day: ___________________
Do you have any allergies to any medications? ________________________________
If so, what type of reaction do you have? ____________________________________
Any prior blood transfusions? ____

PAST MEDICAL HISTORY

Do you have or have you ever had any major illness? (Diabetes, heart disease, high blood pressure, kidney disease, stroke, etc.)
1. ______________________________________Year Diagnosed: __________
2. ______________________________________Year Diagnosed: __________
3. ______________________________________Year Diagnosed: __________

SURGICAL HISTORY

Operation Surgeon Hospital
1. ____ Year: __________
2. ____ Year: __________
3. ____ Year: __________
4. ____ Year: __________
5. ____ Year: __________
6. ____ Year: __________
7. ____ Year: __________
8. ____ Year: __________
9. ____ Year: __________
10. ____ Year: __________

Current Medications: ____
____
____

Do you take Aspirin? ____
Do you take Coumadin? ____
Do you take Plavix? ____
Do you take Pradaxa? ____

Do you have or have you ever had:

Abnormal bleeding or anemia……….Y N
Hypertension ……………………….. Y N
Weight Loss …………………………Y N
Fits/convulsion/seizures…………….. Y N
Double vision ………………………. Y N
Sudden visual loss ………………….. Y N
Decreased hearing ………………….. Y N
Shortness of breath ………………… Y N
Loss of memory…………………….. Y N
Metal in body ………………………. Y N

Difficulty climbing stairs ……….. Y N
Ulcer or Gastritis………………... Y N
Difficulty swallowing …………… Y N
Numbness ……………………….. Y N
Paralysis ………………………… Y N
Diabetes ………………………… Y N
Stroke …………………………… Y N
Heart surgery ……………………. Y N
Chest pain ……………………….. Y N
Claustrophobia ………………….. Y N

Family History

Any illnesses that run in the family: ______________________________
____
____
____

Causes of death for immediate family members: ______________________________
____
____
____

History of prior injuries (work related/ Non work related):

Nature: ______________________________
How treated: ______________________________
Year: ______________________________

Nature: ______________________________
How treated: ______________________________
Year: ______________________________

Nature: ______________________________
How treated: ______________________________
Year: ______________________________

Signature ______________________________ Date: ______________