Dr. Zaidi & Associates Patient History Form Patient Name:_____

PERSONAL HISTORY: Do you now have or have ever had any of the following?:

____Arthritis	____Cancer	____Drug/Alcoholism	____High Blood Pressure	____Migraines
____Allergies	____Chest Pain	____Glaucoma	____High Cholesterol	____Mental Illness
____Asthma	____COPD	____Gout	____Hepatitis	____Osteoporosis
____Blood Disorder	____Diabetes	____HIV/Aids	____Kidney Stones	____Stroke
____Blood Clots	____Depression	____Heart Disease	____Kidney Disease	____Thyroid Disease

Other Significant medical history:_____

MEDICATIONS: LIST ALL CURRENT MEDICATIONS YOU ARE TAKING. ATTACH SEPARATE SHEET IF NECESSARY

Medication	Dosage	Frequency	Medication	Dosage	Frequency

PREVIOUS SURGERIES OR HOSPITALIZATIONS: List any past surgeries or Hospitalizations you have had:

_____ Date:_____ _____ Date:_____

_____ Date:_____ _____ Date:_____

SCREENING HISTORY: Please list the dates for your most recent screenings below:

Mammogram:_____ Location:_____ Pap Smear:_____ Physician:_____

Colonoscopy:_____ Physician:_____ DEXA:_____ Location:_____

Diabetic Eye Exam:_____ Physician:_____ Foot Exam:_____ Physician:_____

DRUG ALLERGIES: Specify any drug allergies or reactions:

_____

SOCIAL HISTORY:

TOBACCO USE: ____Never Smoked _____Smoke/_____ How much/_____How Long _____Chew/Dip _____Quit _____Date Quit

ALCOHOL USE: ____Never Drink _____Rarely Drink _____Drink Often _____# of Drinks Weekly

CAFFEINE USE: ____# Of Cups of Caffeine per Day

DO YOU HAVE AN ADVANCE DIRECTIVE OR LIVING WILL?_____

FAMILY HISTORY: Has any blood relative had any of the following? Y / N

Allergies: Y / N **Who:**	**Cancer: Y / N** **Who:**	**Glaucoma: Y / N** **Who:**	**High Cholesterol: Y / N** **Who:**	**Stroke: Y / N** **Who:**
Anemia: Y / N **Who:**	**Depression: Y / N** **Who:**	**Gout: Y / N** **Who:**	**Kidney Disease: Y / N** **Who:**	**Thyroid Disease: Y / N** **Who:**
Arthritis: Y / N **Who:**	**Diabetes: Y / N** **Who:**	**HIV / AIDS: Y / N** **Who:**	**Mental Illness: Y / N** **Who:**	**Tuberculosis: Y / N** **Who:**
Asthma: Y / N **Who:**	**Drug/Alcoholism: Y / N** **Who:**	**Heart Disease: Y / N** **Who:**	**Migraine: Y / N** **Who:**	**Other:** **Who:**
Blood Disorder: Y / N **Who:**	**Epilepsy: Y / N** **Who:**	**High Blood Pressure: Y / N** **Who:**	**Osteoporosis: Y / N** **Who:**	**Other:** **Who:**

I Affirm that the above information is correct and complete to the best of my knowledge.

_____ _____

Signature of Patient / Legal Guardian **Date**