Medical History

Name: _____

Past Medical and Family History: Please check (√) if you suffer with any of these medical problems. If a family member suffers(ed) with any of these medical problems, write their relation in the corresponding box.

CONDITION	YOU	RELATIVE	CONDITION	YOU	RELATIVE
DIABETES			ANEMIA		
HIGH BLOOD PRESSURE			BLEEDING PROBLEMS		
HIGH CHOLESTEROL			BLOOD CLOTS		
HEART ATTACK			STOMACH ULCER		
STROKE			GALLSTONES		
IRREGULAR HEARTBEAT			HEPATITIS		
COPD			HIV		
ASTHMA			TUBERCULOSIS		
KIDNEY PROBLEMS			GLAUCOMA		
ARTHRITIS			CANCER		

Please list any other personal or family medical issue: _____

_____

Surgical History: Please indicate the year in which you had any of these surgeries.

	YEAR		YEAR		YEAR
APPENDECTOMY		GASTRIC BANDING		SPLENECTOMY	
GALL BLADDER		KNEE REPLACEMENT		ULCER SURGERY	
HYSTERECTOMY		HIP REPLACEMENT		TONSILS	
COLON SURGERY		HEART BYPASS		SPINE SURGERY	
GASTRIC BYPASS		CAROTID ARTERY			
GASRTRIC SLEEVE		THYROID			

Please list any other surgeries and their year: _____

_____

_____

_____

_____

Medical History (cont'd)

Social History:

Marital status: _____

Live with: Alone Spouse Children (grown) Children (dependent)

Occupation: _____

Smoker: ___ packs per day x ___ years Quit in:_____

Alcohol: Daily ___ Drinks per day ___ Occasionally ___ Never ___

Do you use illicit substances or prescription medications without a physician's order? If so, please list. If you are on a methadone maintenance program, please provide us with a copy of your program card: _____

Medications:

Please list medications, herbal supplements, vitamins etc. along with doses and frequency with which you take them.

Medication Name	Dose	Frequency

Allergies (circle):

No Known Allergies PCN Sulfa Erythromycin Codeine Codone
Morphine Statin ACE Inhibitor OTHER:_____

Please Describe Reaction: _____