PATIENT HEALTH HISTORY

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Patient Height _____ Patient Weight _____

Chief Complaint

Reason for today's visit: _____

Past Medical History

Please list any medical conditions (i.e hypertension, diabetes, etc) or major injuries: _____

_____

_____

_____

Surgical History

Surgeries/Hospitalizations	Year	Complications

Have you ever had an antibiotic resistant infection? ☐ Yes ☐ No
If Yes, was it MRSA (Methicillin Resistant Staphylococcus Aureus) or VRF (Vancomycin Resistant Enterococcus)? (Please circle)

Have you ever had problems with anesthesia? ☐ Yes ☐ No
Do you take Aspirin? ☐ Yes ☐ No If Yes, how often : _____

Medications

Including Over the Counter	Dose	Frequency

Patient Name: _____

ALLERGIES/TYPES OF REACTIONS Please circle: **Latex** Yes No **Iodine** Yes No **Shellfish** Yes No **Asthma** Yes No

Family Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

SOCIAL HISTORY

Do you have children? □ Yes □ No How many? _____

Do you live alone? □ Yes □ No Who lives with you? _____

Do you smoke? □ Yes, I've smoked _____ packs of cigarettes per day for _____ years.
□ Yes, I smoke cigars or a pipe.
□ No, I have never smoked.
□ No, I quit _____ years ago. At that time I was smoking _____ packs per day for _____ years.

Do you use street drugs? □ No □ Yes Type _____

Do you drink alcohol? □ No, never (or rarely) □ No, but I used to
□ Yes □ Daily □ 1 or more times a week □1 or more times a month

Are you at risk for AIDS (e.g., sexual orientation, drug abuse, previous blood transfusion)?
□ No □ Yes, please explain _____

□ Deferred by patient: Signature _____