PATIENT PAST MEDICAL HISTORY FORM

Chart # ____________

NAME: ______________________________________ AGE: _______ DOB: __________ DATE: _____________

PRIMARY PHYSICIAN: ___________________________

REASON YOU ARE HERE: __________________________

Have you ever had any of the following health problems? Please check and give dates.

- ☐ Heart Attack ______
- ☐ Heart Failure ______
- ☐ Chest Pain related to heart disease ______
- ☐ High Blood Pressure ______
- ☐ Poor Circulation ______
- ☐ High Cholesterol ______
- ☐ Stroke ______
- ☐ Severe Headaches ______
- ☐ Seizures ______
- ☐ Blackout Spells ______
- ☐ Head Injury ______
- ☐ Meningitis ______
- ☐ Asthma ______
- ☐ Emphysema ______
- ☐ TB ______
- ☐ Pneumonia, severe ______
- ☐ Severe Heart Burn ______
- ☐ Hiatal Hernia ______
- ☐ Stomach Ulcers ______
- ☐ Hepatitis ______
- ☐ Jaundice ______
- ☐ Kidney Infection ______
- ☐ Other Kidney Problem ______
- ☐ Thyroid Problem ______
- ☐ Diabetes ______
- ☐ Arthritis ______
- ☐ Unplanned weight loss ______
- ☐ Enlarged lymphnodes ______
- ☐ Blood Thinner ______
- ☐ Cancer of what ______

Allergies:

Are you allergic to any of the below, state your reaction.

Penicillin ____________________
Sulfa ____________________
"Mycins" ____________________
Aspirin ____________________
Codeine ____________________
Tetanus ____________________
Demerol ____________________
Other ____________________

Other problems not listed above: ____________________________________

Please list surgeries or child births you have had:

Surgery	Date	Surgeon	Hospital

Social History: Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Smoke? ☐ yes ☐ no amount ___ yrs ___

Drink Alcohol ☐ yes ☐ no

Occupation ______________________

Family History: Please check and list family member.

- ☐ Heart Disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Diabetes
- ☐ Cancer
- ☐ Bleeding problem
- ☐ TB

Is your mother alive? ☐ yes ☐ no If not please list cause. ____________________

Is your father alive? ☐ yes ☐ no If not please list cause. ____________________

Please list any medications you are now taking (include over the counter medications ie. aspirin). ______________________

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