Patient History

NAME: _____ **DOB**: _____ **SEX**: MALE FEMALE

Reason For Visit:_____

PERSONAL MEDICAL HISTORY

Have you ever had or been diagnosed with any of the following: (Please circle)

High Blood Pressure? **YES** **NO**

Diabetes? **YES** **NO**

Heart Disease / Heart Attack? **YES** **NO**

Stroke? **YES** **NO**

Asthma? **YES** **NO**

Sleep Apnea? **YES** **NO**

Cancer? **YES** **NO**

Anemia? **YES** **NO**

Anxiety? **YES** **NO**

Depression? **YES** **NO**

Hepatitis? **YES** **NO** TYPE:_____

HIV/AIDS? **YES** **NO**

_____

Have you been **tested** for **HIV** or **Hepatitis**? If so, when?

YES **NO** DATE: _____

Have you ever received a **blood transfusion?** If so, when?

YES **NO** DATE: _____

Other medical issues not listed? Please list:

_____
_____
_____
_____
_____

SOCIAL HISTORY (please circle)

Smoke Tobacco? If so, how much? **YES** **NO** _____

Drink alcohol more than 2 days/wk? How much? **YES** **NO** _____

Take non-prescribed/Illegal drugs? **YES** **NO** _____

Are you married? **YES** **NO** _____

Live alone? **YES** **NO** _____

Have children? How many? **YES** **NO** _____

Employed? If so, what profession? **YES** **NO** _____

Under more than normal stress? **YES** **NO** _____

SURGICAL HISTORY (please circle)

Have you had surgery? (list dates of surgery) **DATE:**

Appendectomy?	**YES**	**NO**	_____
Cholecystectomy? (gallbladder)	**YES**	**NO**	_____
Tonsillectomy?	**YES**	**NO**	_____
Heart Surgery? If so, what surgery?	**YES**	**NO**	_____
Hysterectomy?	**YES**	**NO**	_____
Orthopedic Surgery? If so, what surgery?	**YES**	**NO**	_____
Cosmetic Surgery? If so, what surgery?	**YES**	**NO**	_____

Other Surgery not listed? If so, please list:

_____

_____

HAVE YOU EVER HAD ANY ISSUES WITH ANESTHESIA? YES NO (if so, list any complications that occurred)

_____

FAMILY HISTORY (please circle)

Do you have a family history of any of the following?

Diabetes?	**YES**	**NO** _____	**Any other Medical Family History?** (please list)
Heart Disease?	**YES**	**NO** _____	_____
Cancer? If so, what kind?	**YES**	**NO** _____	_____
Bleeding Disorder?	**YES**	**NO** _____	_____

MEDICATIONS:

PLEASE LIST NAME AND DOSAGE PER DAY:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medications? YES NO

Please list: _____

_____

REVIEW OF SYSTEMS: (please circle)

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

Unexpected weight loss? If so, how much? **YES** **NO**

Unexpected weight gain? If so, how much? **YES** **NO**

New unexplained fatigue? **YES** **NO**

Fevers or chills? **YES** **NO**

Difficulty with vision? **YES** **NO**

Sinus issues? **YES** **NO**

Difficulty swallowing? **YES** **NO**

Chest pain? **YES** **NO**

Shortness of breath? **YES** **NO**

Abdominal pain or symptoms? **YES** **NO**

Skin rashes? **YES** **NO**

Balance issues? **YES** **NO**

Joint pains? **YES** **NO**

Tendency to bleed? **YES** **NO**

Leg pain or swelling? **YES** **NO**

Clotting issues? If so, please explain. **YES** **NO**

_____

Do you take any herbs or OTC supplements? If so, please list. **YES** **NO**

_____

Have you taken any steroids in the last year? **YES** **NO**

Do you take Aspirin/Blood Thinners/NSAIDS Daily? **YES** **NO**

Are you experiencing pain? **YES** **NO**

**If so, on a scale from 1-10, what level of pain are you experiencing? _____

Name of PCP: _____ **Date last seen by PCP? _____**

Were you referred here by a physician? YES NO **Name of Physician: _____**

Have you had any recent bloodwork or diagnostic tests? YES NO

Type: _____Where was it done? _____

WOMEN PATIENTS ONLY:

Number of Pregnancies_____ Number of Children _____ Last Menstrual Period_____ Did you breastfeed? YES NO

Bra Size _____ Last MMG _____ Results _____

COSMETIC PATIENTS ONLY:

How did you hear about us? Circle all that apply:

Website Facebook Instagram Real Self Billboard Friends/Family Other:_____

FOR OFFICE USE ONLY:

Height_____ Weight_____ B/P_____ P_____ T_____ PO_2_____