PATIENT HISTORY

Date: ____________________ Referring Dr.: ______________________________

PERSONAL PROFILE:

Name: ____

Address: ____ Phone: ______________

In case of emergency please notify: ______________________________ Phone: ______________

Date of Birth: ________________________

Age: __________________

Past Medical History:

Yes	No		Yes	No	
❐	❐	Allergies (or unusual reactions to foods or drugs)	❐	❐	Asthma
❐	❐	Bleeding tendency/unusual bruising	❐	❐	Emphysema/bronchitis
❐	❐	Anemia (low, weak blood)	❐	❐	Tuberculosis
❐	❐	Diabetes (sugar)	❐	❐	Pneumonia/pleurisy
❐	❐	Thyroid disease/goiter	❐	❐	Yellow jaundice/hepatitis/liver cirrhosis
❐	❐	Epilepsy (fits, seizures, convulsions)	❐	❐	Gallbladder trouble or gallstones
❐	❐	Arthritis/rheumatism/gout	❐	❐	Stomach trouble/ulcers
❐	❐	Glaucoma	❐	❐	Bowel disorders/colitis
❐	❐	High blood pressure	❐	❐	Blood per rectum
❐	❐	Heart trouble or heart murmur	❐	❐	Cancer/tumors____________________
❐	❐	Rheumatic fever	❐	❐	Kidney or bladder trouble, stones
❐	❐	Stroke or paralysis	❐	❐	Venereal disease (syphilis, gonorrhea)
❐	❐	Phlebitis	❐	❐	Nervous/emotional problems

List any other serious illnesses or injuries you have had (give dates): ____________________________

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Have you ever been admitted to a hospital? ❐ Yes ❐ No If so, please list below starting with most recent:

YEAR	OPERATIONS OR ILLNESS	HOSPITAL NAME AND LOCATION

Do you smoke? ❐ Yes ❐ No How many packs a day? ______________

Do you drink alcohol? ❐ Yes ❐ No Approximate amount per day? ____________________

When was your last T.B. (tuberculosis) skin test? ____________________ Any reaction, describe: ______________

Did you ever have a blood transfusion? ❐ Yes ❐ No If yes, give date ______________

Have you ever been refused insurance or employment because of your health problems? ❐ Yes ❐ No
Explain: ____

Have you ever been medically disabled? ❐ Yes ❐ No
Explain: ____

Have you ever been regularly exposed to any chemicals, toxins, poisons, fumes, smoke or radioactive materials at home or work? ❐ Yes ❐ No
Explain: ____