Patient Pre-History

Name: ______________________________ D.O.B. ______________________

Family Physician: ______________________________ Last Seen: ______________________

Current Medications: ____

____

Allergies to Medication or Foods: ______________________________________

(Women Only) Are you pregnant? ______________ If so, how many months ______________

FAMILY HISTORY (Please indicate the best you can)

Relative	Age, if alive	Age at death	Serious Diseases	Cause of Death
Mother				
Father				
Brothers				
Sisters				
Others				

Do you drink alcohol? ____________________ If so, how much? ______________________

Do you smoke? ________________________ If so, how much? ______________________

Previous Surgeries: (give approximate date) ______________________________________

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***Please indicate with a check mark if you have had significant problems in the following areas:**

Abnormal Bleeding		Hayfever		Numbness in Feet or Legs	
Anemia		Headaches		Polio	
Arthritis		Heart Problems		Recent Weight Loss	
Asthma		Hepatitis B or C		Seizures	
Blood Circulation		HIV		Spinal Bifida	
Cerebral Palsy		Kidneys		Stomach or GI track	
Circulation		Liver Disease or Jaundice		Stroke	
Cramps in Feet or Legs		Lungs		Swelling in Feet or Ankles	
Diabetes		Memory Loss o Dementia		TB	
Gout		Muscular Dystrophy		Thyroid or Adrenal Glands	

______________________________ ______________________

Patient Signature Date

(Parent or Guardian if Minor)