# PAST MEDICAL HISTORY

**TODAY'S DATE** ______________________ **Medical Record Number** ______________

**PATIENT NAME** ______________________ **DATE OF BIRTH** ______________

**EMAIL ADDRESS** ______________________________________________

**MEDICAL DOCTOR** ______________________ **PHONE NUMBER** ______________

**CARDIOLOGIST** ______________________ **PHONE NUMBER** ______________

**PHARMACY** ______________________________________________

## PAST MEDICAL HISTORY

Have you ever been treated for any of the following? (circle all that apply)

| | | | | | |
|---|---|---|---|---|---|
| Aneurysm | Bronchitis | Cancer | Diabetes | Emphysema | Heart Attack |
| Hepatitis | Stroke | Epilepsy | MRSA | Ulcers | High Blood Pressure |
| Heart Disease | Immunodeficiency Disease | | Pacemaker/ICD | Stents | |

Have you ever had surgery? YES / NO Please explain ______________________________

______________________________________________

______________________________________________

Have you ever had an infection that was treated with IV antibiotics or hospitalization? YES NO

Please explain ______________________________________________

## CURRENT MEDICATIONS

| Medication | Dose | Frequency | Condition |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

List any over-the- counter medications (diet, allergy, vitamins, herbal, etc.) ______________

______________________________________________

**ALLERGIES** ______________________________________________

Continued on back →

## SOCIAL HISTORY

Marital Status (circle one) Single Married Divorced Widowed Do you live alone? YES / NO

Children: YES / NO Number ___________ Ages: 0-9 10-17 >18

Alcohol use: YES / NO Circle drinks per week: 1-6 6-12 12-18 >18

Tobacco use: YES / NO Packs per day _______________

## FAMILY HISTORY

Are there any diseases that run in your family?

Diabetes
Rheumatoid Arthritis
Bleeding Disorders
Anesthetic Complications (malignant hyperthermia)

Other: ______________________________________________

Mother - Alive or Deceased Cause: ______________________________________

Father - Alive or Deceased Cause: ______________________________________

**REVIEW OF SYMPTOMS** (circle all that apply to you within the last **two** years)

| | | | | |
|---|---|---|---|---|
| fever | weight changes | double vision | blurring | glasses/contacts |
| deafness | sinusitis | hoarseness | vertigo | chest pain |
| palpitations | shortness of breath | asthma | cough | appetite loss |
| diarrhea | constipation | abdominal pain | hesitancy | incontinence |
| rashes | lesions | bleeding disorders | excess thirst | seizures |
| headaches | depression | hallucinations | blood clots | easy bruising |
| hair changes | decreased energy | speech problems | scars | sleep disturbances |
| swallowing problems | | burning with urination | | menstrual problems |

Other: ______________________________________________

**Musculoskeletal**:

fracture: ______________________________________________

sprain: ______________________________________________

joint pain/swelling: ______________________________________

arthritis: ______________________________________________

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Signature ________________________________________ Date ________________________