Name: _____ Date of Appt: _____

DOB: _____

PATIENT HEALTH HISTORY

DEMOGRAPHICS

1. Race (Mark only one)

- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☒ Some Other Race
- ☐ Black of African American
- ☐ White
- ☐ Decline to State

2. Ethnicity (Mark only one)

- ☐ Hispanic or Latino
- ☐ Not Hispanic nor Latino
- ☒ Decline to State

3. Preferred Language (Mark only one)

- ☐ English
- ☐ Spanish

4. Preferred Communication Method (Mark only one)

- ☐ Home Phone
- ☐ E-mail
- ☐ Mail

MEDICAL HISTORY Do you have or have you been diagnosed with any of the following problems/medical conditions?

☐ No known active medical problems

	No	Yes		No	Yes		No	Yes
Anemia	☐	☐	HIV	☐	☐	Peripheral Vascular Disease	☐	☐
Anxiety	☐	☐	High/Elevated Cholesterol	☐	☐	Pregnant	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐	Progressive Neuro. Disorder	☐	☐
Autoimmune Disorder	☐	☐	Infectious Mononucleosis	☐	☐	Prostate Enlarged	☐	☐
Blood Clots/DVT	☐	☐	Intravenous Drug Abuse	☐	☐	Radiculitis	☐	☐
COPD	☐	☐	Lymphoma	☐	☐	Reflux	☐	☐
Depression	☐	☐	Mitral Valve Prolapse	☐	☐	Renal Failure	☐	☐
Diabetes	☐	☐	Multiple Myeloma	☐	☐	Sleep Apnea	☐	☐
Encephalopathy	☐	☐	Neuralgia	☐	☐	Stomach Ulcer	☐	☐
Epilepsy	☐	☐	Neuritis	☐	☐	Stroke	☐	☐
Heart Disease	☐	☐	Osteoporosis	☐	☐	Thyroid Dysfunction	☐	☐
Hepatitis	☐	☐	Paralysis	☐	☐	Tuberculosis	☐	☐
Cancer	☐	☐	If yes, please specify type of cancer _____					

Any other additional medical history not mentioned? _____

SURGICAL HISTORY Please list any surgical procedures you have had and when.

☐ No previous surgeries or procedures

		Date
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Name: _____ Date of Appt: _____

DOB: _____

PATIENT HEALTH HISTORY (continued)

FAMILY HISTORY Please indicate family members who have been diagnosed with any of the following:

	None	Mother	Father	Brother	Sister
Problems with Anesthesia	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Bleeding/Clotting Problem	☐	☐	☐	☐	☐
Leukemia	☐	☐	☐	☐	☐

SOCIAL HISTORY

1. Home Living Setting (Mark all that apply)

- ☐ Alone
- ☐ Spouse
- ☐ Children
- ☐ Mother
- ☐ Father
- ☐ Nursing Home
- ☐ Assisted Living
- ☐ Other

2a. Tobacco History (Mark only one)

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Smoker, current status unknown
- ☐ Unknown if ever smoked

2b. Do you currently use any of the following tobacco products? (Mark all that apply)

- ☐ None
- ☐ Cigarettes
- ☐ Smokeless tobacco
- ☐ Cigars

2c. Give the closest amount of cigarettes you smoke in an average day?

- ☐ 1/2 pack
- ☐ 2 packs
- ☐ 1 pack
- ☐ 3 packs
- ☐ 1 1/2 packs

3. Alcoholic Beverage Consumption
A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.

- ☐ Abstainer (less than 12 drinks/yr)
- ☐ Light (1-13 drinks/mo)
- ☐ Moderate (4-14 drinks/wk)
- ☐ Heavy (>2 drinks/day)

4. Drug Dependency/Addiction Do you have a dependency or addiction to drugs now or in the past?

☐ No ☐ Yes If yes, mark all that apply

- ☐ Amphetamines
- ☐ Barbiturates
- ☐ Cocaine
- ☐ Codeine
- ☐ Diazepam
- ☐ Heroin
- ☐ Hydrocodone
- ☐ Marijuana
- ☐ Morphine
- ☐ Oxycodone
- ☐ Soma

5. Recreational Drugs Do you use any of the following drugs recreationally?

☐ No ☐ Yes If yes, mark all that apply

- ☐ Amphetamines
- ☐ Barbiturates
- ☐ Cocaine
- ☐ Diazepam
- ☐ Ecstasy
- ☐ Heroin
- ☐ Hydrocodone
- ☐ Marijuana
- ☐ Morphine
- ☐ Oxycodone
- ☐ Soma

6. Will you accept transfusion of blood products? ☐ No ☐ Yes

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PATIENT HEALTH HISTORY (continued)

FOOD ALLERGIES

☐ No known active food allergies

1. _____
2. _____
3. _____

DRUG ALLERGIES

☐ No known active drug allergies

1. _____
2. _____
3. _____

ENVIRONMENTAL ALLERGIES

☐ No known active environmental allergies

1. _____
2. _____
3. _____

IMMUNIZATIONS

	No	Yes
Diptheria-Tetanus-Pertussis (DTP)	☐	☐
Haemophilus Influenza Type B Conjugate Vaccine (HIB)	☐	☐
Hepatitis A (HAV)	☐	☐
Hepatitis B (HBV)	☐	☐
Influenza Vaccine	☐	☐
Measles-Mumps-Rubella (MMR)	☐	☐
Pneumococcal Conjugate Vaccine (PCV)	☐	☐
Pneumococcal Polysaccharide Vaccine (PPV)	☐	☐
Polio-Inactivated Polio Virus (IPV)	☐	☐
Rotavirus Vaccine	☐	☐
Varicella (VZV), Chickenpox vaccine	☐	☐