

**PATIENT HISTORY/ALL INFORMATION IS STRICTLY CONFIDENTIAL**

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Referred by: [ ] Physician \_\_\_\_\_ [ ] Magazine [ ] Friend [ ] Other \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Religion: \_\_\_\_\_

**PAST MEDICAL HISTORY**

**FAMILY HISTORY**

Relation	Age	State of Health	Age of Death	Cause of Death	Check if your blood relations have/had any of the following:	
Father					Arthritis, Gout	
Mother					Asthma, Hay fever	
Brothers					Breast Cancer	
					Diabetes	
					Heart Disease	
Sister					Hypertension	
					Kidney disease	
					Tuberculosis	
					Other	

MEDICATIONS: List medications you are currently taking	ALLERGIES: To any medications or substance

Do you currently take any opioids (pain medication)? \_\_\_No \_\_\_Yes \_\_\_ Oxycodone \_\_\_ Fentanyl \_\_\_ Hydrocodone \_\_\_ Dilaudid \_\_\_ Codeine \_\_\_ Demerol \_\_\_ Methadone \_\_\_\_\_ Other

**PAST MEDICAL CONDITIONS**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Chicken Pox                  | <input type="checkbox"/> Hirsutism (excessive hair growth) | <input type="checkbox"/> Rubella                   |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> HIV                          | <input type="checkbox"/> Hypertension                      | <input type="checkbox"/> Thyroid Disorder          |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Colitis/Ulcers               | <input type="checkbox"/> Hyperlipid                        | <input type="checkbox"/> Scarlet fever             |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Constipation/Rectal bleeding | <input type="checkbox"/> Kidney disease/Stones             | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Anorexia            | <input type="checkbox"/> DES                          | <input type="checkbox"/> Measles                           | <input type="checkbox"/> Syphilis                  |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Pacemaker                         | <input type="checkbox"/> Seizure disorder/epilepsy |
| <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Mumps                        | <input type="checkbox"/> Painful urination/incontinence    | <input type="checkbox"/> COVID 19 ***              |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Heart disease                | <input type="checkbox"/> Phlebitis/blood clots             | <input type="checkbox"/> _____                     |
| <input type="checkbox"/> Bulimia             | <input type="checkbox"/> Headaches/migraines          | <input type="checkbox"/> Pneumonia                         | <input type="checkbox"/> _____                     |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hepatitis/Liver disease      | <input type="checkbox"/> Psychiatric care                  | <input type="checkbox"/> _____                     |
| <input type="checkbox"/> Chemical dependencv |   | <input type="checkbox"/> Rheumatic fever                   | <input type="checkbox"/> _____                     |

**Do you have an Advance healthcare directive? \_\_\_ Yes \_\_\_ No**

An advance healthcare directive, also known as living will, personal directive, advance directive, medical directive or advance decision, is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity.



<p><b>PLEASE COMPLETE OTHER SIDE</b></p>
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**SURGICAL HISTORY**

<i>Date</i>	<i>Surgery</i>	<i>Physician</i>	<i>Hospital</i>	<i>Complications</i>

<b>HEALTH HABITS:</b> Please check which substance you use and describe how much/often you use them.			<b>OCCUPATIONAL CONCERNS:</b> Please check if your employment exposes you to any of the following.		
<input type="checkbox"/>	Alcohol		<input type="checkbox"/>	Stress	
<input type="checkbox"/>	Caffeine		<input type="checkbox"/>	Hazardous Substances	
<input type="checkbox"/>	Drugs		<input type="checkbox"/>	Heavy Lifting	
<input type="checkbox"/>	Tobacco		<input type="checkbox"/>	Other	
<input type="checkbox"/>	Vaping				
<input type="checkbox"/>	OTHER				

Completed by: Patient [ ]      Office Nurse [ ]      Physician [ ]      Other [ ] \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Date reviewed by physician with patient: \_\_\_\_\_

Physician's signature: \_\_\_\_\_

Annual Review of History:

Date reviewed: \_\_\_\_\_

Date reviewed: \_\_\_\_\_

Date reviewed: \_\_\_\_\_

Date reviewed: \_\_\_\_\_

Date reviewed: \_\_\_\_\_

Date reviewed: \_\_\_\_\_

Date reviewed: \_\_\_\_\_

Date reviewed: \_\_\_\_\_



**CHRISTIANA**  
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