Patient Medical History Form

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Name: _____ Occupation: _____ (or previous) Today's Date: _____

Telephone# _____ Work# _____ Date of Birth: _____ Age: ____ Sex: ____

Who is your main medical (primary care) physician? _____

Physician's address: _____ Phone# _____

Referring physician: _____ Height _____ Weight _____

PAST MEDICAL HISTORY/ REVIEW OF SYSTEMS

√ Check boxes (either **YES** or **NO**) for the following illness or conditions. If **YES**, explain below:

YES	NO		YES	NO		YES	NO	
☐	☐	Peripheral Vascular Disease	☐	☐	Diabetes	☐	☐	Bleeding Tendencies
☐	☐	Deep Vein Thrombosis (blood clots)	☐	☐	Heart (chest pain)	☐	☐	Bowel/Bladder(incontinence)
☐	☐	Rheumatologic (gout, RA, SLE, PMR)	☐	☐	Liver (jaundice)	☐	☐	Lung (SOB, cough)
☐	☐	Sciatica	☐	☐	Cancer	☐	☐	Hearing loss
☐	☐	Joint and/or Leg Swelling	☐	☐	Neuro (numbness)	☐	☐	Visual Loss
☐	☐	Fever/Chills	☐	☐	Skin (rash)	☐	☐	Other

If you have checked any of the above, please give details _____

List previous operations (dates, hospitals and name of surgeon) none ☐

List other illness not requiring an operation for which you were hospitalized none ☐

List any serious injuries, broken bones, etc. none ☐

List allergies or sensitivity to medicines or other substances: none ☐

List medications you are currently using (including over the counter drugs) and dosages :

See attached sheet ☐

FAMILY HISTORY

Please check if either your parents or siblings have, or have had, one of the following:

☐ Rheumatologic Conditions ☐ Problems with Anesthesia none ☐

Refer to the illness or conditions listed above and note other family conditions that you are aware of:

SOCIAL HISTORY

Smoke Now? ☐ Yes ☐ No Quit Smoking? ☐ This year ☐ > 1 year ☐ > 5 years ☐ >10 years

Currently smoke or have smoked ____ packs per day for ___ years

Drink Alcohol? ☐ Yes ☐ No How often? ☐ Daily ☐ 1-2 x/week ☐ 1-2 x/month ☐ 1-2 x/year