Patient History Form

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir
Patient's Name (Last) _____ (First) _____ (MI)_____ Previous Name _____ SSN_____
Address Line 1 _____
City, State _____ ZIP _____
Date of Birth MM____/DD____/YYYY____ ☐Female ☐Male ☐Transgender
Home Phone _____ Cell Phone _____ Work Phone _____Ext. _____Email _____

Medical Problems: Have you had (or do you have) any of the following medical problems: (check Yes or No)

YES	NO		YES	NO		YES	NO		YES	NO	
❑	❑	High Blood Pressure	❑	❑	Breast Cancer	❑	❑	Emphysema	❑	❑	Other Kidney Disease
❑	❑	Heart Disease	❑	❑	Colon Cancer	❑	❑	Tuberculosis	❑	❑	Seizure Disorder
❑	❑	Heart Attack	❑	❑	Other Cancer	❑	❑	Sickle Cell	❑	❑	Rec'd Blood Transfusion
❑	❑	Stroke	❑	❑	Abnormal PAP	❑	❑	Anemia	❑	❑	STD
❑	❑	Diabetes	❑	❑	Hepatitis or Jaundice	❑	❑	Arthritis			
❑	❑	Thyroid Disease	❑	❑	Liver/Pancreas Disease	❑	❑	Kidney Stones			
❑	❑	Positive HIV or AIDS	❑	❑	Asthma	❑	❑	Urinary Tract Infection			

Other (please describe)

_____

_____

Past Surgery: Have you had any of the following operations and year of procedure

❑ Appendix - Year: _____
❑ Hernia - Year: _____
❑ Tonsils - Year: _____
❑ Gall Bladder - Year: _____
❑ Heart - Year: _____
❑ Thyroid - Year: _____
❑ Lung - Year: _____
❑ Hysterectomy - Year: _____
❑ Spine/Joint - Year: _____

Other (please describe)

_____

_____

Patient Social History

Use of Alcohol: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily ❑ Previously, Quit
Use of Tobacco: ❑ Never ❑ Previously, Quit ❑ Current ❑ Packs Per Day: _____

Use of Illegal Drugs: **YES** ❑ **NO** ❑ Type: _____ Frequency: _____

Family Medical History

	Age	Disease	Deceased/Cause of Death
Father			
Mother			
Sibling			

In the event a procedure needs to be rescheduled, what hospital do you prefer? _____

Signature: _____ Date: _____

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