

HISTORY FORM The following information is requested to give you the best care and treatment possible. Please answer as thoroughly and honestly as possible.

Full name _____ **Age** _____ **Birth Date** _____ **Today's Date** _____

Reason for Today's Visit _____

MEDICAL HISTORY: Check any and all that apply.

High blood pressure	Abdominal bleeding/stomach ulcers
Heart attack /stroke/fainting spell	Hepatitis/jaundice
Chest pain/tightness	Blood transfusion
Shortness of breath	Blood clots
High cholesterol/triglycerides	Cancer
Irregular heart beat	Seizures
Heart murmur/rheumatic fever	Scar or healing problems
Lung problems/asthma/tuberculosis	Use accutane or steroids in last year
Diabetes	Are you pregnant currently
Psychiatric care (current or past)	Dry or burning eyes
Kidney problems	Thyroid problems
Bleeding disorders	Other medical conditions or admissions
Ankle swelling	Stomach acid regurgitation

PRIOR SURGERY Use space below as needed.

Year	Name of operation	Type of anesthetic, if known	Problems?

CURRENT MEDICATIONS-List all drugs and doses. Include all herbal supplements, vitamins, over-the-counter-medications, and anti-inflammatory drugs. Use space below as needed.

Drug	Dosage	How often				

DRUG ALLERGIES-Include allergies to latex or tape/adhesives please.

Drug						
Reaction						

Do you wear contact lenses, glasses, hearing aid, or dentures? _____

SMOKING Do you smoke? Yes No How much? _____

Primary Care Physician (name) _____ **Last date seen** _____

I certify that all information is true and accurate.

Patient signature (parent if patient is a minor) _____

Additional space for patient information:

Doctor notes—please do not write in this area.

BP _____

HR _____

O₂ Sat _____

Temp _____

Weight _____

Dr. Signature _____