Name: _____ Date:_____

DOB:_____ **Primary Care Physician:**_____

PCP Phone Number:_____

MRSA - STAPH INFECTION? Y/N IF Y, WHERE?_____

PAST MEDICAL HISTORY (CHECK ALL APPLICABLE)

- ☐ Tuberculosis Exposure? Y/N
- ☐ Depression
- ☐ Anxiety
- ☐ Asthma
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Enlarged Prostate
- ☐ Kidney Stones
- ☐ Diverticulitis
- ☐ Gastritis
- ☐ GERD-Reflux-Heartburn
- ☐ Blood Clots
- ☐ Bleeding Disorder - Type?
- ☐ _____
- ☐ Other _____

CANCER Y/N TYPE _____ TREATMENT_____

HEART DISEASE INFO

Chest Pain	Y/N When_____
Congestive Heart Failure	Y/N When_____
Heart Attack	Y/N When_____
Catheterization	Y/N When_____
Heart Stents	Y/N When_____
Heart Vessel Bypass	Y/N When_____
Echo/EKG	Y/N When_____
Stress Test	Y/N When_____
Pacemaker/Defibrillator	Y/N When_____
Irregular Heart Beat	Y/N What Kind?(I.E. Atrial Fibrillation)

PREVIOUS SURGICAL HISTORY (MARK ALL APPLICABLE)

Endoscopy Y/N DATE:_____

Colonoscopsy Y/N DATE:_____ Polyps Y/N Hemmorhoids Y/N

- ☐ Gallbladder Surgery
- ☐ Hernia Surgery
- ☐ Appendix Surgery
- ☐ Thyroid Biopsy/Surgery

Breast Procedures Y/N _____

Bariatric Surgery Y/N Year_____ Type_____

PATIENT NAME:_____ **DOB:** _____

OTHER SURGERIES:

TYPE OF SURGERY YEAR DOCTOR WHERE

_____

_____

_____

DAILY MEDICATION

Names/Doses/Directions: (Include over the counter) **Aspirin Y/N** **Blood Thinners Y/N**

_____ _____

_____ _____

_____ _____

_____ _____

ARE YOU ***ALLERGIC*** TO ANY MEDICATIONS? Y/ N

PLEASE LIST MEDICATION & REACTIONS? _____

_____

_____

ARE YOU ALLERGIC TO LATEX? Y/N

FAMILY HISTORY

Does any family member have any medical conditions? (Mom,Dad,

brother, sister, grandparents,great grandparents) If so please list:

Heart Disease _____

Diabetes _____

Stroke _____

Thyroid Disease _____

Cancer(Who? What Kind?) _____

Other _____

Mother:Living/Deceased Father:Living/Deceased

PERSONAL HISTORY (CIRCLE ONE)

Minor Married Single Divorced Widowed Separated Children #_____

(MARK ALL APPLICABLE)

Tobacco Products Y/N If Y, # pack(s) per day _____

Have you ever smoked? Y/N Started _____ Stopped _____

Snuff/Chew Y/N _____

Alcohol Y/N If Y, what kind/how much_____

Street Drugs Y/N If Y, what type_____