

MEDICAL/FAMILY HISTORY

Patient Name: _____ Age: _____ Height: _____ Weight: _____

Allergies: _____ Medications _____

Medications _____

Reason for Visit: _____

*****PAST MEDICAL HISTORY*****

Past Surgeries: _____

Medical Illness: ___Diabetes, ___High Blood Pressure, ___Heart Disease, ___High Cholesterol,
___Cancer, ___Stroke, ___Asthma, ___Arthritis, ___Anemia, ___Hepatitis, ___Seizures,
___Jaundice, ___Emphysema, ___Bleeding Disorders, ___Auto-immune Disorder, ___Anesth.Prob.

Have you had a transfusion? YES NO If yes, When? _____

Do you smoke? YES NO If yes, how much? _____

Do you drink? YES NO If yes, how much? _____

Illegal Drug Use? YES NO If yes, What kind? _____

Please circle if you have any of the following symptoms:

1. Persistent cough (more than 3 weeks)
2. Bloody Sputum
3. Night Sweats
4. Weight Loss/Gain
5. Anorexia
6. Fever

*****FAMILY HISTORY*****

Does any blood related family member have the following?

Diabetes	YES NO	Who? _____
Hypertension (HPB)	YES NO	Who? _____
Cancer	YES NO	Who? _____
Heart Disease	YES NO	Who? _____
Stroke	YES NO	Who? _____
Asthma	YES NO	Who? _____
Anemia	YES NO	Who? _____
Arthritis	YES NO	Who? _____
Hepatitis	YES NO	Who? _____
High Cholesterol	YES NO	Who? _____
Seizures	YES NO	Who? _____
Jaundice	YES NO	Who? _____
Emphysema	YES NO	Who? _____
(Breathing Difficulties)		
Bleeding Disorder	YES NO	Who? _____
Autoimmune Disorder	YES NO	Who? _____
Anesthesia Problems	YES NO	Who? _____
Other	YES NO	Who? _____

Have you or any member of your family ever had tuberculosis? YES NO Who? _____

