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HISTORY FORM

Date: _____ Name: _____ Date of Birth: _____

Ht: _____ Weight: _____ lbs. Primary Care and/or Medical Doctor: _____

Reason for Visit: _____

List Operations with Dates: _____

Any Recent Problems With:

Lungs YES NO
High Blood Pressure YES NO
Seizures YES NO
Diabetes YES NO
Stomach or Intestines YES NO
Eyes, Ears, Throat YES NO
Bleed or Bruise Easily YES NO
Breasts YES NO
Tuberculosis (TB) YES NO
Have you ever received blood YES NO

Heart YES NO
Stroke YES NO
Cancer YES NO
Urination YES NO
Musculoskeletal YES NO
Enlarged Lymph Nodes YES NO
Skin YES NO

Resistant infection (MRSA, VRE) YES NO
If so, When? _____

Date of last Tetanus Shot: _____

For Women:

Bra size _____ inches _____ cup

Number of children _____

If you answered "YES" to any of the above questions, please provide details:

Current Medications (including vitamins and herbs): _____

Drug Allergies: _____ Circle Reaction: rash, nausea, itching, other _____

Habits: Cigarettes _____ packs/day _____ Alcohol per week: _____

If you do not smoke, did you ever? Y N If yes, how many years? _____ Year you quit _____

Have you ever used other (recreational) drugs? Y N
Please list drug use, recreational/substance abuse: _____

List diseases that run in the family: _____