

Name: _____ Birthdate: ____/____/____ Date: ____/____/____

PATIENT HISTORY

WGT: _____ HGT: _____

Have you ever had or do you have...

- | | | | |
|--------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Malignant Hyperthermia |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cirrhosis of Liver | <input type="checkbox"/> Gout | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Anesthesia Difficulties | <input type="checkbox"/> COPD | <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis (Rheumatoid) | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Arthritis (Osteo) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Elevated Triglycerides | <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Tuberculosis |

Cancer: _____

Other: _____

Other: _____

Drug Allergies: _____

Current Medications with dosage (If necessary, bring list): _____

Surgeries: _____

FAMILY HISTORY

Has anyone in your family had...

- | | | | |
|--------------------------------------------------|-------------------------------------------------|-------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anesthesia Difficulties | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Liver Problem | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis (Rheumatoid) | <input type="checkbox"/> Elevated Triglycerides | <input type="checkbox"/> Lung Problem | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Malignant Hyperthermia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other _____ |

SOCIAL HISTORY

Do you...

- | | | | |
|---------------------------------------------|--------------------------------------|--------------------------------------|----------------------------------------|
| <input type="checkbox"/> Exercise Regularly | <input type="checkbox"/> Use Alcohol | <input type="checkbox"/> Use Tobacco | <input type="checkbox"/> Former Smoker |
| How often: _____ | How Often? _____ | _____ per day | Date Quit _____ |

PLEASE ANSWER BELOW ONLY IF PATIENT IS A CHILD:

In Day Care? yes no

Smokers at home? yes no Smoke outside Smoke inside