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HISTORY FORM

Date: _____

Name: _____

Ht: _____ Weight: _____ lbs.

Reason for Visit: _____

List Operations with Dates: _____

Any Recent Problems With:

Medical Doctor: _____

Lungs: _____

Heart: _____

High Blood Pressure: _____

Stroke: _____

Seizures: _____

Cancer: _____

Diabetes: _____

Urination: _____

Stomach or Intestines: _____

Musculoskeletal: _____

Skin: _____

Eyes, Ears, Throat: _____

Enlarged Lymph Nodes: _____

Breasts: _____

Tuberculosis (TB), Resistant infection (MRSA, VRE)? _____

For Women:

Bra size: _____ in. _____ cup

Number of children: _____

Bleed or Bruise Easily? Y N

Have you ever received blood? Y N

If so, when? _____

Date of last Tetanus Shot: _____

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: _____