HPHS PATIENT MEDICAL HISTORY FORM – please complete this form in its entirety

Name: _____ **Date of Visit**: _____ **Age:** _____

Reason for today's visit: _____ Left Right Bilateral

Referring Physician: _____**Family Physician**: _____

Other Physicians /specialists you are seeing: _____
_____

Medications; including prescriptions, anti-inflammatory drugs or non-prescription medications

MED: _____ **DOSAGE:** _____ **MED:** _____ **DOSAGE:** _____
MED: _____ **DOSAGE:** _____ **MED:** _____ **DOSAGE:** _____
MED: _____ **DOSAGE:** _____ **MED:** _____ **DOSAGE:** _____
PHARMACY NAME: _____ **PHARMACY PHONE NO**: _____

DRUG ALLERGIES: ☐no ☐yes If yes, please list; _____

LATEX ALLERGY: ☐no ☐yes

Medical History: Have you ever had any of the following conditions? **IF YES, PLEASE CIRCLE & EXPLAIN**

Bleeding Problems: ☐none excess bleeding - dvt - blood clots
Cancer: ☐none including skin cancer
Endocrine: ☐none diabetes - thyroid - other
Digestive: ☐none gastric reflux - ulcers - gallstones - hepatitis - colitis - other
Heart Disease: ☐none chest pain - arrhythmias - heart attack - heart failure - high blood pressure peripheral vascular disease - other
Infectious Disease: ☐none HIV - TB - STD - HCV - chronic infections - other
Respiratory: ☐none asthma - cystic fibrosis - emphysema - sarcoid - other
Neurologic: ☐none dementia - depression - seizures - other
Skin: ☐none severe acne - eczema - psoriasis - skin cancer - other
Allergy/Rheumatology: ☐none arthritis - lupus/scleroderma - fibromyalgia - other
Urinary: ☐none bladder infections - prostate - kidney stones - kidney disease - other
Other Medical Problems: ☐none _____

Surgical History: Please list any operations, including plastic surgery, you have undergone along with the dates:
_____
_____

Family History: Please list any major medical problems with parents, grandparents, and/or siblings:

Adopted	☐**no**	☐**yes**	Malignant Hyperthermia	☐**no**	☐**yes**	Malignant Melanoma	☐**no**	☐**yes**
Abnormal Bleeding	☐**no**	☐**yes**	Heart Disease	☐**no**	☐**yes**	Other: _____		
Anesthesia Problems	☐**no**	☐**yes**	Breast Cancer	☐**no**	☐**yes**	_____		

Anesthesia: Have you or anyone in your family ever had a problem with anesthesia: ☐**no** ☐**yes**

If yes please explain_____

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Hospital Admissions: Please list any hospital admissions and reason for admissions:

_____

_____

Review of Systems: Are you currently experiencing any of the following? **If yes, please circle**

Constitutional:	☐none	weakness - fever - weight loss - weight gain
Eyes:	☐none	itching - excess tearing - change in vision or double vision
Ears:	☐none	pain - ringing - buzzing - imbalance - loss of hearing
Nose:	☐none	obstruction - bleeding - chronic drainage
Neck:	☐none	stiffness - swelling - lumps
Mouth/Throat:	☐none	chronic sores - pain - difficulty swallowing
Heart/Lungs:	☐none	chest pain - palpitations - shortness of breath - chronic cough
Digestive:	☐none	heartburn - nausea/vomiting - constipation - diarrhea
Urinary:	☐none	incontinence - retention - bleeding
Muscular:	☐none	swelling - weakness - difficulty moving - leg cramps
Skeletal:	☐none	back pain - joint pain - stiffness
Neurologic:	☐none	headaches - migraines - tremors - numbness and tingling
Psychiatric:	☐none	anxiety - depression - hallucinations - chemical dependency
Skin:	☐none	lesions - rashes - lumps - itching

Social History:

Occupation: _____

Recreational Activities: _____

Smoking: ☐ current every day smoker ☐ current some day smoker ☐ former smoker ☐ never smoked

Alcohol: ☐no ☐yes frequent occasional social

Recreational Drugs: ☐no ☐yes _____

Height: _____ **Weight:** _____ **Date of Birth:** _____

If pertinent, any recent X-rays, CT Scans or MRIs? ☐**no** ☐**yes**
Date studies performed: _____ Location _____

If pertinent, any recent nerve conduction studies (EMG/NCV)? ☐**no** ☐**yes**
Date studies performed: _____ Location _____

Females: Date of last mammogram _____ Location _____

Patient's Signature: _____ Date: _____