HPHS PATIENT MEDICAL HISTORY FORM – please complete this form in its entirety **2022**

Name: _____ **Date of Visit**: _____ **DOB:** _____

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 CITY/STATE:** _____

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

LATEX ALLERGY: ☐ no ☐ yes

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

_____
_____

Hospital Admissions within the last year: Please list any hospital admissions and reason for admissions:

_____
_____

Current or Past Medical History:

Oxygen Dependent	☐**no**	☐**yes**	High Blood Pressure	☐**no**	☐**yes**	Neurological Disease	☐**no**	☐**yes**
History of COPD	☐**no**	☐**yes**	Diabetes	☐**no**	☐**yes**	Auto Immune Disease	☐**no**	☐**yes**
Anticoagulants	☐**no**	☐**yes**	Chronic Infections	☐**no**	☐**yes**	Malignant Melanoma	☐**no**	☐**yes**
Pacemaker	☐**no**	☐**yes**	Communicable Disease	☐**no**	☐**yes**	Other: _____		

History of Heart Attack, Stroke, Stents, Pacemaker: ☐no ☐yes

Bleeding Problems; Excess Bleeding, DVT, Pulmonary Embolism, or Other Bleeding Disorders: ☐no ☐yes

Do you, or does anyone in your family, have a history of malignant hyperthermia? ☐no ☐yes ☐unknown

Have you received the flu shot in the past year? ☐ no ☐ yes

Have you received the pneumonia vaccine since you turned 65? ☐ no ☐ yes

Social History:

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

Vaping: ☐no ☐yes **If yes, please check one:** ☐ with nicotine ☐ without nicotine

Alcohol: ☐no ☐yes **If yes, please circle one:** socially frequently history of alcoholism

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Recreational Drugs (Marijuana, illegal drugs, etc):

Do you have a marijuana card: □no □yes

Admit to using illegal drugs: □no □yes

Admit to history of drug abuse: □no □yes

Height: _____ **Weight:** _____ **Age:** _____

Females: Date of last mammogram _____ **Facility** _____

Have you had a colonoscopy in the last 9 years: □no □yes **If Yes, when?** _____

Patient's Signature: _____ **Date:** _____