HPHS PATIENT MEDICAL HISTORY FORM – please complete this form in its entirety **2024**

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(s) 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

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

Do you use a marijuana card: ☐no ☐yes

Do you use any illicit drugs: ☐no ☐yes

Do you have a history of drug abuse: ☐no ☐yes

TURN PAGE OVER & FILL OUT BACK

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:** _____