HPHS PATIENT MEDICAL HISTORY FORM – please complete this form in its entirety **2025**

Name: _____ Date of Visit: _____ DOB: _____

Who were you referred by: _____

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 tobacco user ☐ former tobacco user ☐ never tobacco user

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 have 3 or more alcohol drinks per day: ☐no ☐yes

Do you use a marijuana card: ☐no ☐yes **Use any illegal drugs:** ☐no ☐yes **History of drug abuse:** ☐no ☐yes

Do you have an Advanced Care Plan: ☐no ☐yes **Name of surrogate decision maker: _____**
Relationship: _____

Are you up to date on your Covid-19 vaccine: ☐no ☐yes

Height: _____ Weight: _____ Age: _____

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

Patient's Signature: _____ Date: _____