Name_____ Date_____

PATIENT HISTORY

Referring Doctor/Person_____ Family Medical Doctor_____

List all your Doctors/Specialists_____

What is the reason or condition that brings you to our office?_____

List all of your medical conditions (i.e diabetes, heart attack, hypertension, stroke, etc_

List all prior surgeries (include date, facility and surgeon)_____

Hospitalizations other then surgery:_____

Do you take any prescription medications? Yes or No?

If yes, please list all your current medications and dosages.

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Blood thinners: Aspirin?

Plavix?

Coumadin?

Lavanox?

Please list the non-prescription medications:

1._____ 3._____
2._____ 4._____

I have reviewed the above:

Physicians signature:_____

NAME_____ DATE_____

ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES?
NO or YES (If yes, please list name of medicine and type of reaction)

_____
_____
_____
_____
_____

HABITS

Tobacco Y N How Much?_____ How Often?_____
Alcohol Y N How Much?_____ How Often?_____
Drugs Y N How Much?_____ How Often?_____
Diet Y N How Much?_____ How Often?_____

FAMILY HISTORY

Has any member of your family (including parents, grandparents, and siblings) ever had the following? Y N (if yes please describe below)

Illness_____ Which family members?_____ Appox. Age when diagnosed

Colon Cancer?_____
Other Cancer (describe)_____
Hypertension
(High blood pressure)_____
Heart Disease_____
Diabetes_____
Strokes_____
Mental disease?
(Anxiety, depression, etc.)_____
Drug or Alcohol addiction?_____
Glaucoma?_____
Bleeding diseases?_____
Other(specify)_____

OBSTETRICAL HISTORY(Women Only): **Date of last menstrual cycle:**_____
How many times were you pregnant?_____
How many vaginal deliveries?_____
How many Caesarian sections?_____
Any complications with pregnancies? Y N (If yes, please explain.)_____
_____

I have reviewed the above:

Physicians' signature:_____