MEDICAL HISTORY

INFORMATION IS STRICTLY CONFIDENTIAL. Please answer all questions completely, and to the best of your knowledge, to enable the doctor to make proper medical decisions.

LAST NAME________________ FIRST________________ AGE ________ SEX ________

HEIGHT ________ WEIGHT ________ RIGHT/LEFT HANDED _______ RELIGION________________ OPTIONAL

OCCUPATION________________ REFERRED BY ________________

SURGERIES

- ☐ Breast Biopsy
- ☐ Breast Surgery (**list type & date**)

____

____

____

- ☐ Abdominal Surgery (**list type & date**)

____

____

- ☐ Other (**list type & date**) ____________

____

____

____

- ☐ Anesthesia Problems (list type)

____

FAMILY HISTORY
(If yes, list relation)**

- ☐ Cancer
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Blood Disease
- ☐ Lung Problems
- ☐ Circulation Problems
- ☐ Diabetes
- ☐ Stroke
- ☐ Drug or Alcohol Abuse
- ☐ Anesthesia Problems

FOR WOMEN

Pregnancies_______ # Deliveries_______

Contraception Type________________

Date of last mammogram ____________

Result________________

Bra Size________________ (*optional)
*breast surgery patients required to answer

MEDICAL CONDITIONS

- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Coronary Artery Disease
- ☐ Heart Failure
- ☐ Arrythmia
- ☐ Cholesterol
- ☐ Lung Problems
- ☐ Cancer
- ☐ Arthritis
- ☐ Intestinal Problems
- ☐ Thyroid Problems
- ☐ Emphysema/Chronic Bronchitis
- ☐ Asthma
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Stroke
- ☐ Circulation Problems
- ☐ Vericose Veins
- ☐ TB
- ☐ HIV
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Blood Clots
- ☐ Bleeding Tendencies
- ☐ Sleep Apnea
- ☐ Psychological
- ☐ Drug Abuse
- ☐ Seizure
- ☐ Chronic Back Pain
- ☐ Wound Healing Issues
- ☐ Easy Bruising
- ☐ Other: ________________

____

____

ADVANCED DIRECTIVE
(for patients over 65)
Do you have a surrogate decision maker?

- ☐ YES
- ☐ NO

LIST ALL FOOD & DRUG ALLERGIES ALONG WITH REACTION

____

____

____

____

____

MEDICATIONS (list dose and frequency)
Include supplements.

____

____

____

____

____

____

____

____

PREFERRED PHARMACY

____
NAME & LOCATION **(CITY & CROSSROADS)**

SMOKING

- ☐ No, never smoked
- ☐ Yes, but I quit as of ____________
- ☐ Yes, I currently smoke ________packs per day for (#) of years ________

ALCOHOL Did you have a drink containing alcohol in the past year?

- ☐ No
- ☐ Yes

If yes, how often?:

- ☐ 1 or less a month
- ☐ 2-4 times per month
- ☐ 2-3 times a week
- ☐ 4 or more times a week

Average # of drinks per occurrence:_______

Race ________________ Ethnicity ________________ Language ________________ ☐ DO NOT WISH TO REPORT

____
PATIENT SIGNATURE (OR RESPONSIBLE PARTY IF MINOR)

____
DATE