PATIENT HISTORY FORM

LAST NAME: _____ FIRST NAME: _____ MI: _____ HEIGHT: _____

SOCIAL SECURITY #: _____ DOB: _____ AGE: ____ WEIGHT: _____

RACE: _____ ETHNICITY: _____ PREFERRED LANGUAGE: _____

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

_____

_____

SURGICAL HISTORY	MEDICAL HISTORY
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Father: ALIVE DECEASED Mother: ALIVE DECEASED

Age: _____ Cause: _____ Age: _____ Cause: _____

SOCIAL HISTORY

Do you smoke?	YES	NO	Do you drink caffeinated beverages? If yes, how many?	YES	NO
Have you ever smoked?	YES	NO	Do you drink alcohol?	YES	NO
Do you use smokeless tobacco?	YES	NO	Have you ever drank alcohol?	YES	NO
Do you use recreational drugs?	YES	NO	Have you had a blood transfusion?	YES	NO

Do you have any allergies to medications? YES NO
If yes, please list any allergies and reactions below:

_____

_____

Are you taking any medications? YES NO If yes, please list all medications below.

_____

_____

_____

_____