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PATIENT MEDICAL HISTORY

Patient Name: _____ **Age:**_____

Today's Date: _____

1. Please list all prior operations which you have undergone and the approximate dates which they took place.

(date) - (surgery)	(date) - (surgery)
_____ - _____	_____ - _____
_____ - _____	_____ - _____
_____ - _____	_____ - _____

2. Please list all prior procedures which you have undergone (i.e. cardiac catheterization, endoscopy, colonoscopy, cystoscopy est.) and the approximate dates which they took place.

(date) - (surgery)	(date) - (surgery)
_____ - _____	_____ - _____
_____ - _____	_____ - _____
_____ - _____	_____ - _____

3. Please list all the medications which you take on a regular basis. Include the dosage and the schedule (i.e. number of times per day) if you can:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Are you allergic to any medications? Yes____ No____

   If yes, which ones? _____ _____

   _____ _____

5. a. Have you ever smoked? Yes____ No____

   b. Do you still smoke? Yes____ No____

      1. If YES,.... How many packs per day? _____

         For how many years have you been smoking? _____

c. If you smoked in the past, for how many years did you smoke? _____

1. How many packs per day did you smoke? _____

2. When did you quit? _____

6. Do you drink Alcoholic beverages? Never_____ Rarely_____ Frequently_____

7. Do you suffer from/or have suffered from any of the following conditions?:

YES	NO	
_____	_____	a. Irregular heart beat (i.e. caediac arrhythmia)
_____	_____	b. Heart Attack
_____	_____	c. Heart murmur or problem with heart valves
_____	_____	d. Asthma
_____	_____	e. Bronchitis or emphysema
_____	_____	f. Pneumonia
_____	_____	g. Chronic cough
_____	_____	h. Wheezing
_____	_____	i. Difficulty breathing
_____	_____	j. Allergies (such as to dust, plants, animals, mold, etc.)
_____	_____	k. Are you able to climb steps?
_____	_____	l. Sinus problems, stuffy nose, nosebleeds, runny nose
_____	_____	m. Problems with sleep? If yes, please list: _____
		_____
		_____
_____	_____	n. Are you sleepy during the day?
_____	_____	o. Have you ever had any form of cancer? If yes, which type?_____
_____	_____	p. Stomach ulcers
_____	_____	q. Do you have acid indigestion, heartburn, frequent belching , sour taste in mouth?
_____	_____	r. Do you have a history of hiatus hernia or gastrosophageal reflux?
_____	_____	s. Diarrhea, Constipation?
_____	_____	t. Blood in stool or black stool?
_____	_____	u. Problems urinating, frequent urination or urinary infections?
_____	_____	v. Thyroid Disease?

_____ _____ w. WOMEN ONLY: Ovarian, uterine or vaginal related problems?
If YES, explain:

_____

_____

_____

_____ _____ x. MEN ONLY: Prostate, testicular or penile related problems?
IF YES, explain:

_____

_____

_____

_____ _____ y. Swelling of the feet or legs?

_____ _____ z. Chest pains?

8. Do any diseases run in your family? _____Yes _____No
If yes, please list

_____

_____

_____

_____

9. Please explain your current symptoms which have led you to seek medical care at this time.

_____

_____

_____

_____