PATIENT HISTORY FORM

Name:	Birthdate:	Height:	Weight:

Past Medical History: Have you been diagnosed with any of the following? (Check yes or no)

High blood pressure	☐ Yes ☐ No	Blood clots	☐ Yes ☐ No	Hepatitis/Liver disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Pulmonary Embolism	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
High cholesterol	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No
COPD/emphysema	☐ Yes ☐ No	Ulcer/GERD	☐ Yes ☐ No	Rheumatoid arthritis	☐ Yes ☐ No
Cardiac disease/heart attack	☐ Yes ☐ No	Hyper/Hypothyroidism	☐ Yes ☐ No	Cancer (if yes, list below)	☐ Yes ☐ No

Other medical problems :

Past Surgical History (List Procedures Below)

Medications (Please list below)

Allergies (Please list below – allergies that produce symptoms of difficulty breathing, rash/hives, throat swelling, etc.)

Family History

Blood Clot	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No
Pulmonary Embolism	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Malignant hyperthermia	☐ Yes ☐ No

Social History

Do you smoke?	☐ Yes ☐ No	If yes, amount per day:
Do you use alcohol?	☐ Yes ☐ No	If yes, amount per day:

What is your occupation?

Review of Systems: Have you experienced the following recently? (Check yes or no)

Fever, night sweats	☐ Yes ☐ No	Difficulty urinating	☐ Yes ☐ No	Intolerance to heat/cold	☐ Yes ☐ No
Unexplained weight loss	☐ Yes ☐ No	Muscle pain	☐ Yes ☐ No	Easy bruising	☐ Yes ☐ No
Sore throat	☐ Yes ☐ No	Joint pain	☐ Yes ☐ No	Environmental allergies	☐ Yes ☐ No
Chest pain	☐ Yes ☐ No	Skin rash/sores	☐ Yes ☐ No	Visual problems	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Arm/leg numbness	☐ Yes ☐ No		
Abdominal pain	☐ Yes ☐ No	Gait difficulty	☐ Yes ☐ No		

Patient Signature:	Physician Signature:
Date:	Date: