PATIENT HEALTH HISTORY FORM

PLEASE COMPLETE IN BLACK INK

TODAY'S DATE

LAST NAME	LEGAL FIRST NAME	MI	DATE OF BIRTH

REVIEW OF SYSTEMS

DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING?

Check all items either No or Yes	No	Yes, Now	Yes, Past
GENERAL/CONSTITUTIONAL			
Chills			
Fatigue			
Fever			
Weight Gain			
Weight Loss			
EAR/NOSE/THROAT			
Glasses or Contacts			
Dentures			
Decreased Hearing			
RESPIRATORY			
Cough			
Shortness of Breath			
Wheezing			
CARDIOVASCULAR			
Chest Pain			
Do you see a Cardiologist?			
If yes, Who?			
GASTROINTESTINAL			
Exposure to Hepatitis			

Check all items either No or Yes	No	Yes, Now	Yes, Past
HEMATOLOGY			
Bleeding Disorders			
Easy Bruising			
Prolonged Bleeding			
Recent Transfusion			
WOMEN ONLY			
X-ray may be taken; do you think you are pregnant?			
MUSCULOSKELETAL			
Numbness			
Joint Stiffness			
Leg Cramps			
Muscle Aches			
Back Pain			
Neck Pain			
Sciatica			
Swollen Joints			
Trauma to Arm(s)			
Trauma to Hip(s)			
Trauma to Knee(s)			
Trauma to Ankle(s)			
Weakness			

Check all items either No or Yes	No	Yes, Now	Yes, Past
PERIPHERAL VASCULAR			
Rash			
Do you see a Vascular Physician?			
If Yes, Who?			
NEUROLOGIC			
Balance Difficulty			
Coordination Problems			
Difficulty Walking			
Tingling			
PSYCHIATRIC			
Anxiety			
Depressed Mood			
Difficulty Sleeping			
OTHER PROBLEMS/DISEASES			

ALLERGIES

	No	Yes			No	Yes			No	Yes	
None				Sulfa				Codeine			
Latex				Aspirin				Other:			
Penicillin				Shellfish				Other:			

What was your reaction?

ANESTHESIA

	No	Yes	
Have you ever had anesthesia?			
If yes, Did you have an problems?			

If yes, What kind of problems?

The information on this form is correct to the best of my knowledge.

X_____ _____

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE DATE REVIEWED BY PROVIDER DATE