PATIENT
HISTORY FORM

(Must be completed Annually)

PATIENT NAME: _____ DATE COMPLETED: _____

PAST MEDICAL HISTORY

☐ Anemia ☐ Arthritis ☐ Asthma ☐ Blood Clots ☐ Cancer: _____

☐ COPD ☐ Depression ☐ Diabetes ☐ Fibromyalgia ☐ Fracture ☐ Gout

☐ Heart Disease ☐ Hepatitis ☐ HIV ☐ Hypertension ☐ Irregular Heartbeat

☐ Liver Disease ☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Stroke ☐ Seizure

☐ Thyroid Disease ☐ Chemical Dependency and/or Alcoholism ☐ History of Blood Transfusion

☐ Other: _____ Do you have a pacemaker? □ Yes / □ No

PAST SURGICAL HISTORY

(Please list all previous surgical procedures you have had)

Surgical Procedure	Side	Date of Procedure

MEDICATIONS

(Please list all prescription, over the counter medications and supplements)

Medication	Dosage	Frequency

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ALLERGIES

Are you allergic to: Sulfa Drugs □ Yes / □ No **Latex?** □ Yes / □ No **Adhesive?** □ Yes / □ No

Please list any additional allergies you have: _____

SOCIAL HISTORY

Have you ever used tobacco? □ No □ Yes □ Formerly Used

Type of Tobacco: □ Cigarette □ Cigar □ Chewing Tobacco

Current Smoking Status: □ Non Smoker □ Smoker □ Former Smoker
□ Currently Chew Tobacco □ Former Chew Tobacco

Have you ever tried to quit using tobacco? □ No □ Yes □ Not Applicable / Never Used
Tobacco Type: _____ Date Quit: _____

Do you drink alcohol? □ No □ Yes □ Formerly
If Yes: Type of Alcohol _____ Frequency _____ # of Drinks_____

Do you drink/consume caffeine □ Yes / □ No

FAMILY HISTORY

☐ Arthritis ☐ Blood Clots ☐ Diabetes ☐ Heart Disease

☐ Hypertension ☐ Osteoporosis ☐ Seizure ☐ Stroke

☐ Cancer:_____ ☐ Other

Patient Signature: _____

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