 *Bruce D. Smith, M.D - John E. Winter, M.D. - Michael J. Shannon, M.D.*

 *Bret R. Winter, M.D. - Gary I. Molk, D.O. – Daniel Kisicki, M.D.*

 *Lindsay Tully, PA-C - Kelli A. Chambers, PA-C*

**Patient Health History**

(Please Fill Out Carefully and Completely)

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Physician (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known Drug Allergies

 Drug: Reaction: Do you have an allergy to metal Yes \_\_\_\_ No \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, what metal(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have an allergy to latex Yes \_\_\_\_ No \_\_\_\_

 If yes, confirmed by lab test Yes \_\_\_\_ No \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Prescription and Non-Prescription Medications: Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: Dose: Frequency:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Past Medical History:

 Have you ever been diagnosed with:

 Yes No Yes No

HIV/AIDS □ □ Hiatal Hernia/GERD/Ulcer □ □

Alcoholism/Drug Abuse □ □ Gout □ □

Alzheimer’s/Dementia □ □ Jaundice/Hepatitis □ □

Anemia □ □ High Cholesterol □ □

Heart Attack/Angina □ □ High Blood Pressure □ □

Asthma □ □ Kidney Disease/Failure □ □

Arthritis □ □ Cirrhosis/Liver Disease □ □

 If yes, what kind: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lyme Disease □ □

Irregular Heart Beat □ □ Migraine Headaches □ □

Cancer □ □ Multiple Sclerosis □ □

 If yes, what kind: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Osteoporosis □ □

Stroke/TIA □ □ Parkinson’s □ □

Heart Failure □ □ Epilepsy/Seizure Disorder □ □

Emphysema/COPD/ Psoriasis/Skin Disease □ □

 Pneumonia □ □ Peripheral Vascular Disease □ □

Heart Disease □ □ Scoliosis □ □

Crohns Disease/IBS □ □ Sleep Apnea □ □

Anxiety/Depression/ Lupus □ □

 Nervous Breakdown □ □ Back Problems □ □

Diabetes □ □ Thyroid Disease □ □

Chronic Bronchitis □ □ Hemophilia □ □

Have you:

 Yes No

 Taken Cortisone or Steroids in the last 3 months? □ □

 Taken Blood Thinners in the last month? □ □

 Take Aspirin regularly? □ □

 Ever had problems with anesthesia? □ □

Surgical History

 Date Surgery Attending Physician/Facility

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Family History

 Has any blood relative ever had:

 Yes No Who? (Father, Mother, Brother, etc…)

Cancer □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Tuberculosis □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Heart Attack/Disease □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 High Blood Pressure □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Stoke □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Blood Clots □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Alcoholism/Drug Abuse □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Lung Disease □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Liver Disease □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Kidney Disease □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Problems with Anesthesia □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social History

 Yes No Yes No

Do you…

 Smoke Cigarettes: □ □ Ever had withdrawals? □ □

 *If yes, how many*

 *packs per day?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Use “street” drugs □ □

 Chew Tobacco? □ □ Drink/Use Caffeine? □ □

 *If yes, how much*

 Drink Alcohol □ □ *daily?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *If yes, how many,*

  *how often?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Parent/Guardian Signature Date