PATIENT HISTORY/ASSESSMENT FORM

Please answer all questions to the best of your ability. Date: _____

Patient Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Address: _____ Phone: (hm) _____ (wk) _____ (cell) _____

City/State/Zip: _____ **REFERRING PHYSICIAN:** _____

Current Employer: _____ Current Occupation: _____

ALLERGIES: List any allergies you have to Medications, foods or environment:

_____

_____

Do you have a **LATEX** sensitivity or allergy?..... ☐ Yes ☐ No

Following a medical, surgical or dental procedure, have you ever had any unexplained itching, hives, swelling or anaphylactic reaction?..... ☐ Yes ☐ No

Have you had symptoms such as sneezing, coughing, wheezing, rash or hives when handling rubber products, balloons, latex gloves or Band-Aid's?..... ☐ Yes ☐ No

CURRENT MEDICATIONS: Please list all current medications (and dosage, if known). Include over the counter drugs, herbal remedies, nutritional supplemants, etc.: _____

_____

_____

_____

HISTORY: Please indicate if you have previously or are currently experiencing any of the following problems:

Condition	Past Problem	Current Problem	Explain any current symptoms or treatment
Anticoagulant therapy/... (blood thinners)	☐ Yes ☐ No	☐ Yes ☐ No	
Arthritis	☐ Yes ☐ No	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	
Heart Trouble	☐ Yes ☐ No	☐ Yes ☐ No	
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No	
Convulsions	☐ Yes ☐ No	☐ Yes ☐ No	
Lung Trouble	☐ Yes ☐ No	☐ Yes ☐ No	
Acute Infections	☐ Yes ☐ No	☐ Yes ☐ No	
Thyroid Trouble	☐ Yes ☐ No	☐ Yes ☐ No	
Kidney Trouble	☐ Yes ☐ No	☐ Yes ☐ No	
Bleeding Tendencies	☐ Yes ☐ No	☐ Yes ☐ No	
Fatigue	☐ Yes ☐ No	☐ Yes ☐ No	
Skin Rashes	☐ Yes ☐ No	☐ Yes ☐ No	
Other	☐ Yes ☐ No	☐ Yes ☐ No	
If yes, specify: _____			

Past Surgeries, including date: _____

_____

_____

_____

_____

_____

_____

Have you had any reaction to anesthesia? ☐ Yes ☐ No

HISTORY CONTINUED:

Indicate if you had the following, or mark as NA (not applicable)

Flu vaccine: ☐ Yes ☐ No Date: _____ Last Menstrual period: Date: _____ ☐ N A
Tetanus shot: ☐ Yes ☐ No Date: _____ Mammogram: Date: _____ ☐ N A
Pneumovax: ☐ Yes ☐ No Date: _____ Chest X-ray: Date: _____ ☐ N A

Do you use tobacco products? ☐ Yes ☐ No ☐ Quit (when?)
Product: _____ Amount: _____ How long: _____
Do you drink alcohol? ☐ Yes ☐ No ☐ Quit (when?) _____
Product: _____ Amount: _____ How long: _____

Do you use street/other illicit drugs? ☐ Yes ☐ No ☐ Type/Quantity: _____
Dou you use seat belts? . . . . . Yes☐No☐
If you have children, do you use car safety seats? . . . . . Yes☐No☐
Within the last year, have you been hit, slapped, kicked or otherwise physically injured by someone? . . . Yes☐No☐
List any hazards associated with employment: _____

_____
Any other problems you have not previously listed:

Family History:

Relation	Age	General Health/Diseases	If deceased, at what age and cause of death if known
Father			
Mother			
Brother(s)			
Sister(s)			
Spouse			
Children			

Other relative(s) with significant/similar problems to your complaint? _____
_____

Is the person completing this form the patient? ☐ Yes ☐ No
If no, state name and relationship to patient _____