

COMPREHENSIVE PATIENT HISTORY

Date Form Completed _____ Patient Acct. # _____

Patient Name: _____

(Last) (First) (Middle)

Patient Vitals: Height _____ Weight _____ Age _____ Occupation _____

Left or Right Handed? (circle one) Primary Care Physician _____

Who referred you to our office? _____

Are you being treated by a Cardiologist? Name _____

* * * * *

Please list your previous Hospitalizations/Surgeries/Serious Injuries/Illnesses:

PLEASE LIST ANY DRUG ALLERGIES _____

What was your reaction? _____

Please list current medications _____ Do you smoke: Yes ___ No ___

_____ If so, how many packs? ___

Use of Drugs Yes ___ No ___ Type/Frequency _____

Use of Alcohol Yes ___ No ___ Frequency _____

Excessive exposure at home or work to metal particles? Yes or No

Have you ever had the following:				High Blood Pressure		Y	N	
Cancer	Y	N	Diabetes *	Y	N	Heart Trouble	Y	N
Arthritis/Gout	Y	N	Stroke	Y	N	Bleeding Tendency	Y	N
Acute Infections	Y	N	MRSA	Y	N	Asthma	Y	N

*Do you take insulin Y N

Family Medical History:

Diseases

If deceased, cause of death

Father _____

Mother _____

Regarding your general health, please indicate if you have experienced any of the following:

- | | | |
|---------------------------------------|--------------------------------|----------------------------|
| Recent weight change _____ | Memory loss or confusion _____ | Nausea or vomiting _____ |
| Fever, chills, nightsweats _____ | Stomach pain _____ | Depression _____ |
| Joint stiffness or swelling _____ | Shortness of breath _____ | Blood in stool _____ |
| Difficulty in walking _____ | Asthma or wheezing _____ | Urinary difficulties _____ |
| Swollen glands in neck _____ | Slow to heal after cuts _____ | Anemia _____ |
| Sinus problems _____ | Anemia _____ | Sleep Apnea _____ |
| Hearing loss _____ | Rash or itching _____ | |
| Light headed or dizzy _____ | Change in skin color _____ | |
| Numbness or tingling sensations _____ | Change in hair or nails _____ | |

Reviewed by Doctor _____ Date _____