PATIENT HISTORY

Please answer the following questions relating to your past medical/surgical history. Please complete this form and bring it with you to your scheduled appointment. The form may be completed by you or an identified responsible party.

Patient Name Gender ❑ Male ❑ Female

Date of Birth Social Security Number

Address City State Zip code

Daytime Phone # Cell phone #

Patient Medical History (Check any past/current problems)**:**

- ❑ Confused
- ❑ Unresponsive
- ❑ Eyes
- ❑ Ears
- ❑ Nose
- ❑ Mouth
- ❑ Sinus
- ❑ Throat
- ❑ Skin Problem
- ❑ Rash
- ❑ Hives
- ❑ Hearing
- ❑ Speech
- ❑ Difficulty Walking
- ❑ Weakness
- ❑ Breathing Problems
- ❑ Positive TB Test
- ❑ Vision
- ❑ Loose/Chipped Teeth
- ❑ Capped/False Teeth
- ❑ Circulation Problems
- ❑ Stomach Problems
- ❑ Weight Loss
- ❑ Weight Gain
- ❑ Bowel Problems
- ❑ Liver Problems
- ❑ Hepatitis
- ❑ Gallbladder
- ❑ Kidney
- ❑ Pain – Location:
- ❑ Frequent Falls
- ❑ Immune System Problems
- ❑ Chronic Cough
- ❑ Other: ______________________
- ❑ Abnormal Pap smears
- ❑ Reproductive organs
- ❑ Dialysis
- ❑ Thyroid
- ❑ Heart problems
- ❑ Blood clots
- ❑ Bleeding
- ❑ High Blood pressure
- ❑ Stroke
- ❑ Diabetes
- ❑ Seizures
- ❑ Epilepsy
- ❑ Cancer – Location:
- ❑ Bones
- ❑ Lung Problems
- ❑ TB

Explain any checked boxes

Problems with anesthesia – Explain

List any previous hospitalizations/surgeries/invasive procedures

List all allergies (include drug allergies)

List all medications

PATIENT MEDICAL HISTORY

Wound History:

Wound site

Reoccurring wound ❑ YES ❑ NO

Treatment history:

❑ Dressing(s) utilized (list dressing(s) used)

❑ Medications utilized (list the medications)

Surgical treatments

Length of treatment

Response to treatment

Date of last treatment?

Where was treatment provided? (clinic, physician office, etc)

Family History:

Father: ❑ Living ❑ Deceased Age at Death: Cause of death:

Mother: ❑ Living ❑ Deceased Age at Death: Cause of death:

Have you had a family member with any of the following? If so, check the appropriate box and identify the family member.

- ❑ Alcoholism ___________________________
- ❑ Bleeding Disorder ___________________________
- ❑ Thyroid Disease ___________________________
- ❑ Heart Disease ___________________________
- ❑ Epilepsy ___________________________
- ❑ Seizures
- ❑ Cancer ___________________________
- ❑ Asthma ___________________________
- ❑ Diabetes ___________________________
- ❑ Stroke ___________________________
- ❑ Migraine ___________________________
- ❑ TB ___________________________
- ❑ Kidney disease ___________________________
- ❑ Wounds ___________________________
- ❑ Other: ___________________________

____

- ❑ Mental Disorders

____

- ❑ High Blood Pressure

____

Social History:

Marital status

Children ❑ YES ❑ NO

Do you live alone? ❑ YES ❑ NO

If you needed help to care for yourself, is there someone available to help you? ❑ YES ❑ NO

Tobacco ❑ YES ❑ NO

Recreational drugs ❑ YES ❑ NO

Alcohol ❑ YES ❑ NO

Caffeine ❑ YES ❑ NO

Do you have an advanced directive? ❑ YES ❑ NO

If yes, ❑ living will ❑ durable power of attorney ❑ health care directive

Patient, Parent or Guardian Signature Date

(*If completed by someone other than patient, relationship to patient)*