

# PATIENT HISTORY SHEET

PATIENT NAME: DATE OF BIRTH: TODAY’S DATE:

**PRIMARY CARE PHYSICIAN OR REFERRING DOCTOR:**

**CURRENT MEDICATIONS** (INCLUDING VITAMINS AND SUPPLEMENTS)**:**

**MEDICATIONS ALLERGIES:** YES NONE (**UNKNOW)**

### ENVIRONMENTAL/SEASONAL ALLERGIES

(INCLUDING LATEX, CONTACT ALLERGIES)**:** YES NONE (**UNKNOWN**)

### PLEASE INDICATE ALL ILLNESSES AND HEALTH PROBLEMS FOR BOTH YOURSELF. (CHECK APPROPRIATE BOX)

**YOURSELF YOURSELF**

YES NO YES NO

CANCER KIDNEY PROBLEMS

ASTHMA FEVERS

LUNG DISEASE/ COPD PROSTATE OBSTRUCTION

DIABETES STROKE

HEART ATTACK TUBERCULOSIS

HEART DISEASE POLIO

HEART MURMUR GLAUCOMA

HIGH BLOOD PRESSURE NERVE OR PSYCHIATRIC DISEASE

RINGING IN THE EARS UNUSUAL CHILDHOOD DISEASE

HEARING LOSS STOMACH ULCERS/ HEART BURN

THYROID PROBLEMS NECK PROBLEMS

WEIGHT LOSS BLEEDING PROBLEMS

ARTHRITIS HPV

DIZZINESS HIV VIRUS

**MIGRAINES HEPATITIS** type:

**PLEASE LIST ALL SURGERIES:**

**IMMUNIZATIONS:** UP TO DATE? **YES NO IMMUNIZATIONS FOR: FLU SHIINGLES PNEUMONIA YEAR:**

**DO YOU USE TOBACCO? DO YOU USE ALCOHOL? DO YOU USE ASPIRIN? RECREATIONAL DRUGS?**

**CURRENT FORMER NEVER CURRENT FORMER NEVER DAILY SOMETIMES NEVER CURRENT FORMER NEVER**