PATIENT HISTORY

Patient Name: ___________________________________DOB: _______________ Date: __________________

Do you have or have a history of the following:

Lungs:
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Asthma
- ☐ Chronic bronchitis
- ☐ Morning cough

Vascular:
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Prior myocardial infarction
- ☐ Functional murmur
- ☐ Rhythm disorder
- ☐ Pacemaker placement
- ☐ Thrombophlebitis
- ☐ High cholesterol
- ☐ Blood transfusion

Other systemic:
- ☐ Diabetes mellitus
- ☐ Hay fever
- ☐ Osteoporosis
- ☐ Thyroid disorder
- ☐ Renal disorder
- ☐ Bladder disorder
- ☐ Liver, stomach, or bowel disease
- ☐ Hepatitis ________
- ☐ Glaucoma
- ☐ Arthritis
- ☐ Epilepsy (seizure)
- ☐ Convulsive disorder
- ☐ Disorder of consciousness, fainting
- ☐ Headache

Other medical history:

____

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List all medications you are currently taking, including over the counter medications:

Medication	Strength	How often		Medication	Strength	How often

List your allergies: ____

Social History:

Do you drink alcohol? _________ If yes, how many drinks per day? ______________________

Do you use recreational drugs? ________ If yes, what type of drug and how often? ___________

Have you ever been exposed to HIV (AIDS)? _____________________________

PLEASE COMPLETE OTHER SIDE ALSO