

Patient Pre-History

Name: _____ D.O.B. _____

Family Physician: _____

Current Medications: _____

Allergies to Medication or Foods: _____

(Women Only) Are you pregnant? _____ If so, how many months _____

FAMILY HISTORY (Please indicate the best you can)

Relative	Age, if alive	Age at Death	Serious Diseases	Cause of Death
Mother				
Father				
Brothers				
Sisters				
Others				

Do you drink alcohol? _____ If so, how much? _____

Do you smoke? _____ If so, how much? _____

Previous Surgeries: (give approximate date) _____

*** Please indicate with a check mark if you have had significant problems in the following areas:**

Recent Weight Loss	Stomach or GI Track	Hepatitis B or C
Headaches	Swelling in Feet or Ankles	HIV
Arthritis	Abnormal Bleeding	TB
Asthma	Anemia	Polio
Hayfever	Liver Disease or Jaundice	Cerebral Palsy
Diabetes	Thyroid or Adrenal Glands	Muscular Dystrophy
Heart Problems	Kidneys	Spinal Bifida
Blood Circulation	Cramps in Feet or Legs	Seizures
Circulation	Gout	Stroke
Lungs	Numbness in Feet or legs	Memory Loss or Dementia

Patient Signature
(Parent or Guardian if Minor)

Date