

Patient History Form

Patient Name: _____

BP _____ HT _____ WT _____

***Please List all allergies including medications, foods and anything environmental (including Latex)**

<u>Allergies</u>	<u>Reactions</u>

Patient Nickname/ Goes by: _____

Emergency Contact: _____

Emergency Contact Phone: _____

Primary Care Physician and phone #: _____

***Please list ALL current medications you are taking including vitamins, herbals, etc.**

<u>Medication</u>	<u>Dose and Frequency</u>	<u>Medication</u>	<u>Dose and Frequency</u>

***Have you ever had problems with any of the following? If yes please explain:**

<u>Problem</u>	<u>Yes or No</u>	<u>If yes, please explain</u>
<u>Cardiac</u>		
Heart Disease/ Chest Pain/Heart Attack	Y N	
Irregular Heartbeat/Pacemaker	Y N	
High Blood Pressure	Y N	
Family history of cardiac problems	Y N	
<u>Respiratory</u>		
Asthma/Wheezing	Y N	
Sleep Apnea/Use a CPAP	Y N	
Pneumothorax	Y N	
Bronchitis	Y N	
Emphysema	Y N	
Sinus Problems	Y N	
Recent Cough or Cold	Y N	
Trouble lying flat	Y N	
Current oxygen use at home	Y N	
<u>Neurologic</u>		
Epilepsy/Seizures	Y N	
Severe Headaches/Migraines	Y N	
Stroke	Y N	
Mental Illness/Depression	Y N	
Spinal Cord Injury	Y N	
<u>Endocrine</u>		
Diabetes	Y N	
Thyroid Disease	Y N	
Cortisone/Steroid Use in past year	Y N	
<u>Renal</u>		
Bladder Problems	Y N	
Kidney Disease	Y N	
Prostate Problems	Y N	
Could you be pregnant	Y N	
<u>Hematologic</u>		
Anticoagulant/blood thinner	Y N	
Recent aspirin/anti-inflammatory	Y N	
Bleeding Problems	Y N	
Blood Clots	Y N	
Blood Transfusion	Y N	



OVER

