Today's Date____/____/____

# PATIENT HISTORY RECORD

Name_____ Date of Birth____/____/____

## ILLNESSES

Check ☐ where you or members of your family Have had the following illnesses or problems:

| You | Your family | |
|---|---|---|
| ☐ | ☐ | Alcoholism |
| ☐ | ☐ | Anemia |
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Cancer, tumor |
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | Drug abuse |
| ☐ | ☐ | Depression |
| ☐ | ☐ | Eczema, hives, rashes |
| ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Eye problems |
| ☐ | ☐ | Glaucoma |
| ☐ | ☐ | Heart disease |
| ☐ | ☐ | High blood pressure |
| ☐ | ☐ | Kidney/bladder problems |
| ☐ | ☐ | Liver disease, hepatitis, yellow jaundice |
| ☐ | ☐ | Lung disease, tuberculosis |
| ☐ | ☐ | Mumps, measles, chicken pox |
| ☐ | ☐ | Nervous breakdown, mental illness |
| ☐ | ☐ | Phlebitis |
| ☐ | ☐ | Rheumatic fever |
| ☐ | ☐ | Rubella, German measles |
| ☐ | ☐ | Stroke |
| ☐ | ☐ | Suicide attempt |
| ☐ | ☐ | Thyroid disease |
| ☐ | ☐ | Ulcer in stomach/duodenum |
| ☐ | ☐ | Uncontrolled bleeding |
| ☐ | ☐ | Venereal disease |
| ☐ | ☐ | Other illness |
| ☐ | ☐ | Anesthetic reaction |

## MENSTRUAL HISTORY

Age when period started _____

Number of days period lasts_____

Number of days between period_____

## MEDICINE ALLERGIES

List those to which you are allergic:

_____

_____

_____

Have you ever had a blood transfusion?
☐ Yes ☐ No
Any reaction?
☐ Yes ☐ No

Do you smoke? ☐ Yes ☒ No
Packs per day_____

Alcohol consumption
How many drinks/day or week?_____

## MEDICINES YOU ARE TAKING

List medicines, birth control pills, or vitamins you take with or without a prescription.

_____

_____

_____

_____

## HOSPITALIZATIONS

List serious illnesses and injuries or operations and approximate year

| Year | Serious illness, injury or operation | Hospital | City & State |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## PREGNANCY HISTORY

Enter the number of:

Times pregnant.....

Premature birth.....

Miscarriage.....

Abortion.....

Live births.....

Living children.....

Any problems or complications:

| Year | Length Preg | TYPE OF DELIVERY Spont. | Forceps | C.S. | Length of Labor | Complications | Sex | Wt. |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
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