

COMPLETE MEDICAL HISTORY

Patient's Name: _____

Date: _____

Family/Primary Phys: _____

Patient's Date of Birth: _____

Are you or could you be pregnant? Yes No

Comments: _____

Have you ever had a bone density test? Yes No

Advanced Directives: Yes No

Living Will: Yes No

Power of Attorney: Yes No

General Medical History - (Have you or any members of your family had:)

	You	Family	N/A	COMMENTS
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis (any kind)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Prior Surgery: (include dates)

- 1 _____ Date: _____
- 2 _____ Date: _____
- 3 _____ Date: _____
- 4 _____ Date: _____

Medication Allergies: (Include surgical soaps, tape, iodine, latex, etc.)

- 1 _____
- 2 _____
- 3 _____
- 4 _____

Current Medications:

Please list ALL medications you are currently taking (name and dosage).

- | | |
|---------|---------|
| 1 _____ | 5 _____ |
| 2 _____ | 6 _____ |
| 3 _____ | 7 _____ |
| 4 _____ | 8 _____ |

Pharmacy and Location: _____

Social History:

Tobacco Products: Yes No
 How Much _____ How Long _____

Alcohol: Yes No
 How Much _____ How Long _____

Recreational Drugs: Yes No
 How Much _____ How Long _____

For Office Use Only: PFSH Reviewed/Updated			
Date	Initials	Date	Initials