



Medical History Form

NAME: _____ DATE OF BIRTH: _____ PATIENT ID: _____

Height: _____ Weight: _____ Age: _____ Sex: M F

Occupation: _____ Disabled Retired Currently Unemployed

Family Doctor: _____ Who Referred you to NHOC? _____

Reason for Today's Visit: (which side, right, left, both): _____

When did you start having a problem? _____

Was it related to an accident? No Yes Work Related MVA other: _____

Is there an Attorney involved? No Yes Attorney: _____

Patient Medical History

- Heart Trouble
- High Blood Pressure
- Stroke
- Diabetes
- Arthritis
- NONE
- Gout
- Seizures
- Mental Illness
- Kidney Trouble
- Osteoporosis
- Bleeding
- Alcoholism
- Serious Injuries
- Lung Disease
- Tuberculosis
- Phlebitis
- Anemia
- Stomach Ulcers
- Liver Trouble
- Thyroid Trouble
- Blood Clots/DVT
- AIDS
- Hepatitis
- Cancer
- Other

Previous Surgeries	<input type="checkbox"/> NONE	Hospital/Date	Previous Surgeries	Hospital/Date

Known Problems for you with Anesthesia? Yes No Describe: _____

Medications

ALLERGIES or Intolerance to Medications: None Yes, If yes please list medication and reactions: _____

Latex Allergy/Sensitivity: Yes No

Physician Reviewed:

Initials: _____ Date: _____



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Medications you currently take (including over the counter medications, vitamins, herbs, & prescribed drugs):

Medication	Dosage	Medication	Dosage	Medication	Dosage

Family Medical History (Mark if any of these run in your family)

- Heart Trouble Stroke Arthritis Seizures Kidney Trouble Alcoholism
- High Blood Pressure Diabetes Gout Mental Illness Bleeding Cancer
- Blood Clots/DVT Other: _____

Family history of problems with Anesthesia? No Yes Describe: _____

Social History (Mark if any of these run in your family)

- Do you live alone? Yes No Do you exercise regularly? Yes No Describe: _____
- Tobacco Use? Yes No Type: Cigarettes Chew # of packs/day _____ #of years used: _____
- Alcohol Consumption? Yes No # of drinks/week: _____ History of Alcoholism? Yes No
- Recreational Drug Usage? Yes No Type/Amount/How Often: _____

<input type="radio"/> Single	<input type="radio"/> Married	<input type="radio"/> Divorced	<input type="radio"/> Separated	<input type="radio"/> Widowed
Children:	<input type="radio"/> No	<input type="radio"/> Yes # _____		
Do you live alone?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> One-Story	<input type="radio"/> Two-story/steps

Review of Systems (recent or current conditions)

- Weight Change Visual Changes Blackouts Incontinence Joint Pain
- Fever / Chills Ear Pain / Ringing Shortness of Breath Urinary Frequency Joint/Limb Swelling
- Night Sweats Nosebleeds Cough Urinary Burning Lumps/Masses
- Poor Appetite Hoarseness Nausea / Vomiting Frequent Headaches Irregular Periods
- Rash Difficulty Swallowing Stomach Pain Seizures Vaginal Discharge
- Insomnia Tooth/Gum Trouble Frequent Diarrhea Numbness Pregnant
- Depression Chest Pain Frequent Constipation Weakness _____
- Anxiety Abnormal Heartbeat Blood in Stool Backache _____

Patient Signature: _____ Date: _____

Physician Reviewed:

Initials: _____ Date: _____