

PATIENT HISTORY

Thank you for completing this form. This information will assist the doctors and staff in providing quality care.

Patient Name: _____		Date: _____	
Ht. _____	Wt. _____	Age _____	DOB _____
Gender: <input type="radio"/> M <input type="radio"/> F		Are you pregnant? <input type="radio"/> Yes <input type="radio"/> No	

Race: <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Asian <input type="radio"/> Black or African American	
<input type="radio"/> Native Hawaiian or Other Pacific Islander <input type="radio"/> White <input type="radio"/> Unknown <input type="radio"/> Other _____ <input type="radio"/> Refuse	
Primary Language: <input type="radio"/> Arabic <input type="radio"/> Bulgarian <input type="radio"/> Central Khmer <input type="radio"/> Chinese <input type="radio"/> English <input type="radio"/> French	
<input type="radio"/> German <input type="radio"/> Haitian / Haitian Creole <input type="radio"/> Hebrew <input type="radio"/> Hindi <input type="radio"/> Italian <input type="radio"/> Japanese <input type="radio"/> Korean <input type="radio"/> Polish	
<input type="radio"/> Portuguese <input type="radio"/> Russian <input type="radio"/> Somali <input type="radio"/> Spanish <input type="radio"/> Castilian <input type="radio"/> Swahili <input type="radio"/> Thai <input type="radio"/> Urdu <input type="radio"/> Vietnamese	
<input type="radio"/> Other _____ <input type="radio"/> Refuse	
Ethnicity: <input type="radio"/> Hispanic or Latino <input type="radio"/> Non-Hispanic or Latino <input type="radio"/> Unknown <input type="radio"/> Other _____ <input type="radio"/> Refuse	

MEDICAL HISTORY: Have you or a family member had, or do you currently have any of the following?					
<u>Systemic</u>	<u>Self</u>	<u>Family</u>	<u>Vascular</u>	<u>Self</u>	<u>Family</u>
Anemia	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Congestive Heart Failure	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Bleeding Disorders	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Sickle Cell	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Heart Disease	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Clotting Disorders	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Thyroid	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No			
Autoimmune Disorders	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<u>Other</u>	<u>Self</u>	<u>Family</u>
Fibromyalgia	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Systemic Connective Tissue Diseases	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Dermatitis / Eczema	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
			HIV / AIDS	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<u>Lung</u>	<u>Self</u>	<u>Family</u>	Seizures	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	History of Keloid Scar Formation	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Bronchitis	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	Herpes:		
Emphysema	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	a) Cold sores	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Pneumonia	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	b) Shingles	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
			c) Other	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Are you currently taking long-term corticosteroids? <input type="radio"/> Yes <input type="radio"/> No					
Any other diseases, conditions or problems we should know about? _____					

Patient Name: _____ Date: _____

SURGERY HISTORY: List ALL prior surgeries and year

SOCIAL HISTORY:

Do you smoke? Yes No How many packs per day? _____ How many years? _____

Alcoholic beverage use? Yes No How much? _____ How often? _____ How many years? _____

Recreational drug use? Yes No Name of drug(s) _____

MEDICATION HISTORY

Have you ever taken any alpha-blocker medications such as: Flomax (tamsulosin), Hytrin (terazosin), Cardura (doxazosin), Uroxatral (alfuzosin)? Yes No

Have you had problems with tranquilizers, narcotic medications or anesthetics? Yes No

If yes, what was the problem? _____

Has anyone in your family ever had a problem with tranquilizers or narcotics? Yes No

Have you recently taken Acutane, Cordarone or migraine medication? Yes No

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy Phone _____

Pharmacy Address: _____

MEDICATIONS List all medications that you are currently taking, including over-the-counter medicines or remedies

Drug Name	Strength	How often used	Drug Name	Strength	How often used

ALLERGIES & REACTION List all medication, food and other items that you are allergic to. If you have no allergies, write "NONE".

Are you sensitive to iodine / tape / latex? Yes No

If you had an allergic reaction, did you have:

A skin rash or hives? Yes No

Wheezing or trouble breathing? Yes No

Hay fever or runny nose? Yes No

PATIENT PRINTED NAME

STAFF SIGNATURE	DATE / TIME	PATIENT SIGNATURE	DATE / TIME
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