PATIENT MEDICAL HISTORY FORM

Patient Name: _____
(LAST) (FIRST) (MIDDLE)

DOB: _____ Age: _____ MR#: _____ Today's Date: _____

SMOKING STATUS

Please place a check (√) in appropriate box:

Never Smoked	☐	Current Everyday	☐
Former Smoker	☐	Current Some Days	☐

History of Smoking:
How many packs per day? _____
How many years? _____

ALLERGIES

Please place a check (√) in the box if you have ever had an allergic reation to any of the following:

Betadine	☐	Seafood	☐
MRI/CT Contrast	☐	Tomatoes	☐
Strawberries	☐		

List any other allergies to food or medication:
_____
_____

MEDICATION

Please place a check (√) in box if you are currently on any of the following medications:

ActoPlus Med	☐	Glucophage	☐	Metaglip	☐
Avandamet	☐	Glucovance	☐	Metformin	☐
Diabex	☐	Glumetza	☐	PrandiMet	☐
Diafomin	☐	Glyburid Met	☐	Riomet	☐
Fortamet	☐	Janumet	☐		

MEDICAL HISTORY

Please place a check (√) in box if you have ever been diagnosed with any of the illness listed below:

Asthma	☐	High Blood Preassure	☐
Cancer	☐	Kidney Disease	☐
Diabetes	☐	Lung Disease	☐
Heart Disease	☐	Shortness of Breath	☐

SURGICAL HISTORY

Please list all prior surgeries with estimated year the surgery was performed.

_____
_____
_____

I attest the above information is correct to the best of my knowledge. I have read and I understand the contents of this form. I have had the opportunity to ask questions regarding the information on this form.

_____ _____
Signature of Patient/Guardian **Date**

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