



**PATIENT HISTORY FORM:**

Patient Name:

DOB:

<b>Personal History:</b>	<b>Yes</b>	<b>No</b>	<b>Details: (Include medications or surgeries)</b>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Headache/Migraine	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health Illness	<input type="checkbox"/>	<input type="checkbox"/>	
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	
ENT Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma/Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Chest Pain/Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	
Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
Changes in Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>	
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	
Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	
STD	<input type="checkbox"/>	<input type="checkbox"/>	
HIV/Aids	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Menstrual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Gout	<input type="checkbox"/>	<input type="checkbox"/>	
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Weight Changes	<input type="checkbox"/>	<input type="checkbox"/>	
Erectile Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	
Other Medical Illness	<input type="checkbox"/>	<input type="checkbox"/>	



Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

<b>Social History:</b>	<b>Yes</b>	<b>No</b>	<b>Details: (Including how often, how many, etc.)</b>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	
Children	<input type="checkbox"/>	<input type="checkbox"/>	
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	
Energy Drinks	<input type="checkbox"/>	<input type="checkbox"/>	
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	
Employed	<input type="checkbox"/>	<input type="checkbox"/>	
Stress	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Surgical History:</b>	<b>Yes</b>	<b>No</b>	<b>Details: (Including year)</b>
Appendix	<input type="checkbox"/>	<input type="checkbox"/>	
Gallbladder	<input type="checkbox"/>	<input type="checkbox"/>	
CABG	<input type="checkbox"/>	<input type="checkbox"/>	
Tonsills	<input type="checkbox"/>	<input type="checkbox"/>	
Back Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Hip Replacement	<input type="checkbox"/>	<input type="checkbox"/>	
Knee Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Cataract Repair	<input type="checkbox"/>	<input type="checkbox"/>	
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Other Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Family History:</b>	<b>Yes</b>	<b>No</b>	<b>Details: (Including what side of family )</b>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
High BP	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	