PATIENT HISTORY

Name _____ Date_____

Height_____Weight_____

PAST MEDICAL HISTORY	YES	NO	YEAR	COMPLICATIONS/COMMENTS
Cardiovascular/Heart Disease				
High Blood Pressure				
Heart Attack (MI)				
Pacemaker				
Arrhythmia (i.e. fibrillation)				
Edema (Leg/Ankle Swelling)				
Endocrine				
Diabetes				
Hypothyroid				
Hyperthyroid				
Gastrointestinal				
Ulcer				
Heartburn (Dyspepsia)				
Bloody or Tarry Stool				
Neurological				
Seizures				
Stroke (CVA)				
Asthma				
Cancer (where?)				
Kidney Disease				
Liver Disease				
Rheumatic Disease				
Osteoporosis				
Skin Problems				
Psychiatric problems				
Hepatitis				
HIV / AIDS				

MEDICATIONS	AMOUNT PER DAY

ALLERGIES	REACTION

HABITS	YES	NO	HOW MUCH (PER DAY/PER WEEK)
Cigarettes/Cigars			
Alcohol			
Drugs (Specify)			

ILLNESS/SURGERY	YEAR	COMPLICATIONS	COMMENTS