Patient Health History

Marking Instructions

- Use only a number 2 pencil.
- Fill in the complete oval as shown below.

	Correct Mark	Incor	ect Mark	5 🗖	V X	
1.	Are you allergic to any of th	e follo	wing?		rigani a dia	
		Yes				Yes
	Adhesive tape		Metal			
	lodine		Seafor	bc		
	Latex		Contra	st Dye	ija i j	
2.	Mark if you have been diag	nosed	with any	of the fo	llowing:	
		Yes				Yes
	Breast Cancer		Gastro	ointestina	al	
	Lung Cancer		Reflu	X		
	Skin Cancer		Hepat			
	Throat Cancer		Stoma	ch Ulcer		
	Prostate Cancer					
	Other Cancer		A second second	ou pregnate Enlarg	the same of the sa	000
	Migraine Headache		and the same and the same of t	Failure		
	Cataracts		Stroke	9		
	Glaucoma		E-STEEL STATE			
	Olddoniu .		Anxie	ty		0
	Nasal Allergies		Depre	OR AND PROCESSION AND ADDRESS OF THE	1	
	Sleep Apnea		Diabe		- 1	0
	Designation of the Party of the Control of the Cont	C C	Thyro	id Dysfu	nction	
	Blood Clots/DVT		Anemia			
	High/Elevated		THE WAS PROPERTY.	THE RESERVE AND PERSONS ASSESSMENTS		
	Cholesterol		Hemo	huma		U
	Heart Attack		HIV			
	High Blood Pressure		MIN			
	Asthma					
	Chronic Bronchitis					
	Emphysema					
	Tuberculosis					
3.	Mark family members who	have h	een diag	nosed v	ith anv o	f
3.	the following:				Brother	Siste
		<u>None</u>	Mother	Father	biotiler	Jiste
	Problems with Anesthesia				0	
	Thyroid Cancer					
	Lung Cancer					
	Unspecified Cancer					
	Hearing Loss before age 20					
	Hearing Loss after age 20					
	Heart Disease					
	High Blood Pressure					
	Asthma					
	Stroke					
1	Distrator					



or this roll	owing?				
Yes		Yes	Dat	e of Appt:	
169	Metal				
	Seafood	0 -	4.	Mark if retired. Yes	<u> </u>
	Contrast Dye				
<u> </u>	Contrast Dye				
liagnosed	with any of the following:		5.	Tobacco Use:	
Yes		Yes		Mark your tobacco use.	
	Gastrointestinal		-	□ None □ Cigarette	es
	Reflux			□ Smokeless Tobacco □ Cigars	
	Hepatitis		- 1		
	Stomach Ulcer		-	Give the closest amount of cigarette	s you
	Control of the Control of the Control of the Control		- 155	smoke in an average day.	
	Are you pregnant?		-	☐ 1/2 pack ☐ 2 packs	
	Prostate Enlargement			□1 pack □3 packs	
	Renal Failure			1 1/2 packs	
	Notice Failure		-	Control of the Contro	Charles May
	Stroke	O =	-	Alcoholic Beverages - A drink is 1 she	
		_	-	liquor or 1 glass of wine or 1 bottle/can of	of beer.
	Anxiety	0 =	-	Less than 12 drinks/yr	
	Depression		-	1-13 drinks/mo	
0		T. Marie		4-14 drinks/wk	
	Diabetes		-	>2 drinks/day	
	Thyroid Dysfunction			Control of the contro	
	Thyroid Dysidifiction		6.	Do you use drugs recreationally?	
	Anemia			Yes	
	Hemophilia		_		
	Петториша				
	LIIV		7.	Caffeine Use (coffee, tea, chocolate, c	ola.
	HIV	0 -		other caffeinated drinks):	X 18
		_		□ None □ 2-3 per d	lav
				1 per day 4 or mor	
				T per day 4 of filor	6
			8.	Are you exposed to second hand sn	noke?
			- 0.	Yes	
de a la acce	heen diagnosed with any o	•)
vno nave	been diagnosed with any o		9.	Mark if patient attends daycare.	
	Mother Father Brother	Sister		Yes	ì
None)
-					
sia 🗆	0 0 0		_		
sia 🗆		0	_ 10	Will you accent transfusion of blood	1
sia 🗆	0 0 0		10.	Will you accept transfusion of blood	
sia 🗆			-	products if necessary? Yes	5
sia					5
sia				products if necessary? Yes)
sia				products if necessary? Yes Home Living Situation (mark all that	apply)
e 20				products if necessary? Yes	apply)
e 20				products if necessary? Yes Home Living Situation (mark all that	apply)
e 20			11.	Products if necessary? Home Living Situation (mark all that Alone With spo	apply) ouse
e 20			11.	Home Living Situation (mark all that Alone With spo With children In nursin With mother With fatt	apply) ouse
e 20			11.	Home Living Situation (mark all that Alone With spo	apply). ouse ng home
e 20			11.	Home Living Situation (mark all that Alone With spo With children In nursin With mother With fatt	apply). ouse ng home

LP3267 Rev. 8/12

Bleeding/Clotting Problem

	Yes
Fever	
Sleeping problems	
Unintentional weight loss	0
Unintentional weight gain	
Blurred vision	
Itchy eyes	
Loss of vision	
Painful eye	
Dizziness	
Ear drainage	
Hearing loss	
Ear pain	
Ringing in the ears	
Nasal congestion	
Frequent nosebleeds	
Post-nasal drainage	
Belching sour material into throat	
Hoarseness or	_
other voice changes	
Mouth ulcers	
Partials or dentures	
Blacking out or fainting	
Chest pain	
Heart murmur	
Irregular heartbeats	
Leg cramps	
Swelling of ankles	
Frequent non-productive cough	
Frequent productive cough	
Shortness of breath	
Snoring (excessive)	
Wheezing	
Abdominal pain	
Diarrhea	
Heartburn	
Nausea	
Trouble swallowing	
Painful swallowing	
Vomiting	
Painful joints	
Stiffness in joints	
Swelling of joints	

	Yes
Change in sense of smell	
Change in sense of taste	
Headache	
Severe face pain	
Seizures	
Tremor	
Appetite is increased	
Fatigue	
Cold feeling	
Bleed excessively after injury	
Bruise easily	
Masses (lumps) in armpit	
Masses (lumps) in neck	
Masses (lumps) in groin	
Hives	
Sneezing	

Thank you
for
completing
this
questionnaire!