PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish. There is room to explain your answers more completely on the back of the second page. **Please Type or Print.**

NAME:_____ **DATE OF BIRTH**:_____

How did you hear about Dr. Gartside?:_____

PURPOSE FOR VISIT: What is the main reason you are seeing the doctor today?

_____

_____

MEDICATIONS

Please list any medications ***including aspirin, vitamins, over-the-counter, or herbal medication***?

Medication Name	***Dose***	***How Often Taken***

ALLERGIES TO MEDICINES, ETC

Medication Name	***Type of Reaction***

Do you have environmental Allergies?	☐**Yes** ☐**No**	Please list:
Do you have food Allergies?	☐**Yes** ☐**No**	Please list:
Do you have a known allergy to Latex?	☐**Yes** ☐**No**	

PAST MEDICAL HISTORY ***Have you ever been DIAGNOSED with any of the following problems?***

	Yes No	**Year**	**Comment**
CANCER (please list type):	❒❒		
Cardiovascular			
Do you have a pacemaker	❒❒		
High/Elevated Cholesterol	❒❒		
High Blood Pressure	❒❒		
Other Heart Problems	❒❒		
Respiratory			
Asthma	❒❒		
COPD	❒❒		
Tuberculosis	❒❒		

NAME:_____**DATE OF BIRTH**:_____

PAST MEDICAL HISTORY ***Continued***

	Yes No	Year	Comment
Gastrointestinal			
Hepatitis	❒❒		
Reflux	❒❒		
Stomach ulcers	❒❒		
Kidney			
Renal Failure	❒❒		
Mental and Emotional			
Depression (requiring treatment)	❒❒		
Anxiety (requiring treatment)	❒❒		
Hematologic/Immunity			
Anemia	❒❒		
HIV/AIDS	❒❒		
Bleeding after surgery	❒❒		
Blood transfusion	❒❒		
Blood Clots/Pulmonary Embolus	❒❒		
Other Not Listed Above			
Problem:	❒❒		
Diabetes:	❒❒		

PAST HOSPITALIZATIONS FOR MEDICAL PROBLEMS ONLY - LIST SURGERIES BELOW

Have you ever been hospitalized for a medical problem before? ☐**Yes** ☐**No** Please list below:

Year	Reason for Admission	Date	Physician

PAST SURGICAL HISTORY

Year	Procedure	Surgeon

FAMILY HISTORY ***Please mark all that apply:***

					Maternal		Paternal	
	Mother	**Father**	**Brother**	**Sister**	**Grandma**	**Grandpa**	**Grandma**	**Grandpa**
Specific Anesthesia problem	❒	❒	❒	❒	❒	❒	❒	❒
CANCER (please list type) under check mark	❒	❒	❒	❒	❒	❒	❒	❒
Cardiovascular:								
High Blood Pressure	❒	❒	❒	❒	❒	❒	❒	❒
Heart Problems	❒	❒	❒	❒	❒	❒	❒	❒
Respiratory:								
Asthma	❒	❒	❒	❒	❒	❒	❒	❒
Lung Cancer	❒	❒	❒	❒	❒	❒	❒	❒
Neurologic:								
Stroke	❒	❒	❒	❒	❒	❒	❒	❒
Hematologic								
Bleeding/clotting problem	❒	❒	❒	❒	❒	❒	❒	❒

NAME:_____**DATE OF BIRTH**:_____

SOCIAL HISTORY

Have you ever smoked? ☐**Yes** ☐**No** Do you smoke now? ☐**Yes** ☐**No**		Comments (indicate amount per day):
Do you drink alcohol? ☐**Yes** ☐**No**		Comments (indicate amount per week):
Do you use any recreational drugs? ☐**Yes** ☐**No**		Comments (indicate frequency):

REVIEW OF SYSTEMS ***Have you RECENTLY had any of the following problems?***

	Yes No	Comment
General Health Problems:		
Fever or Chills	❒❒	What is your current:
Night Sweats	❒❒	
Weight Loss/Gain > 10 lbs/1 month	❒❒	**Height:** _____ **Weight:** _____
Fatigue	❒❒	
Head/Neck Problems:		
New Headache	❒❒	
Vision/Eye problems	❒❒	
Earache, loss of hearing	❒❒	
Chronic sinus infections	❒❒	
Cardiovascular Problems:		
Blacking out/Fainting	❒❒	
Chest pain	❒❒	
Irregular heartbeat/palpitations	❒❒	
Swelling of ankles	❒❒	
Respiratory Problems:		
Frequent cough	❒❒	
Shortness of breath	❒❒	
Wheezing	❒❒	
Gastrointestinal Problems:		
Difficulty swallowing/food sticking in throat	❒❒	
Abdominal pain	❒❒	
Constipation	❒❒	
Diarrhea	❒❒	
Heartburn	❒❒	
Nausea/Vomiting	❒❒	
Neurologic Problems:		
Numbness or Tingling	❒❒	
Seizures	❒❒	
Urologic Problems:		
Blood in urine	❒❒	
Difficulty starting urine stream	❒❒	
Burning	❒❒	
Leaking of urine	❒❒	
Mental and Emotional Problems:		
Depression (requiring treatment)	❒❒	
Anxiety (requiring treatment)	❒❒	
Endocrine Problems:		
Diabetes	❒❒	
Thyroid disorder	❒❒	
Other	❒ ❒	Explain:
Hematologic Problems:		
Swollen Lymph Nodes	❒❒	
Bruising easily	❒❒	
Bleeding into joints	❒❒	
Skin Problems:		
Itching	❒❒	
Rash	❒❒	

SIGNATURE: _____ **DATE:** _____