PATIENT – MEDICAL HISTORY

Date: ____________________ Chart # ____________________

Patient Name: ______________________________ DOB: __________________ Age: ____________

Have you had any of the Following?:		
Seizures	**YES**	**NO**
Headaches/Dizziness	**YES**	**NO**
Eye Problems	**YES**	**NO**
Diabetes	**YES**	**NO**
Angina (Chest Pain)	**YES**	**NO**
Heart Disease/Heart Attack	**YES**	**NO**
High/Low Blood Pressure	**YES**	**NO**
Colitis/Bowel Disorder	**YES**	**NO**
Respiratory/Lung Disease	**YES**	**NO**
Thyroid Problems	**YES**	**NO**
Blood Clots	**YES**	**NO**
Abnormal Bleeding/Anemia	**YES**	**NO**
Kidney Disease	**YES**	**NO**
Gastric Ulcers/Stomach	**YES**	**NO**
Jaundice/Liver Disease	**YES**	**NO**
Hepatitis	**YES**	**NO**
Pacemaker/Defibrillator	**YES**	**NO**
HIV	**YES**	**NO**
Tuberculosis	**YES**	**NO**
Shingles	**YES**	**NO**
Cancer	**YES**	**NO**
Any Implants/Breast/Metal,etc..	**YES**	**NO**

Have you ever smoked or used Tobacco products?	YES	NO
If Yes: How long?		
How many packs per day?		
Have you quit Smoking and When?		
Have you ever used alcohol products?	YES	NO
If Yes: How long?		
How much?		
Have you quit using Alcohol and When?		

List any and all Surgeries below:

Any Family History of the Following? If Yes Please List Who:		
Cancer:	YES	NO
Diabetes:	YES	NO
Heart Problems:	YES	NO
Lung Disease:	YES	NO
Epilepsy:	YES	NO
Kidney Problems:	YES	NO
Arthritis:	YES	NO
Psychiatric Disorder:	YES	NO

Have you had any previous Radiation Therapy?	YES	NO
If Yes: When and Where?		
Have you had any previous Chemotherapy?	YES	NO
If Yes: When and Where?		
Are you ALLERGIC to any Medications, Food, Dyes, Latex etc…	YES	NO
If Yes: Please List:		

List any Special Diet: ____

Medical Doctor: ____

Chemotherapy Doctor: ____

Surgeon: ____

Pharmacy: ____

Hospital Preference: ____

Patient Signature:____

FEMALE PATIENTS ONLY:

How Many Pregnancies?: _______________

Last Menstrual Period? : ________________

Your Age at First Pregnancy?: ___________

Have You Taken Hormones? : ___________

Did You Breast Feed? : _________________

Reviewed By: _________________________