

Date _____

Account # _____

DOB _____

Provider _____

MEDICAL HISTORY (DR. GOOCH #48 / 448)

(circle one)

Name _____

MEDICAL HISTORY: Please check if you have ever had problems with any of the following:

- | | | | | | | |
|--|-------------------------------------|---|----------------------------------|--|--------------------------------|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Bleeding Disorder | | <input type="checkbox"/> Ear, nose, throat, mouth | | <input type="checkbox"/> High Blood Pressure | | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Intestinal | <input type="checkbox"/> Kidney | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stomach Ulcers | | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Prostate | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Gynecologic | <input type="checkbox"/> Skin | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Blood Transfusion | | <input type="checkbox"/> Mental Health | | <input type="checkbox"/> Drug/Alcohol Abuse | | |

Other: _____

FAMILY HISTORY: Please check if any of the following conditions exist within your family: (NOT including yourself)

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> Bleeding Problems | | | |

Other: _____

Current Medications: (name and amount)

Medical Allergies

Reaction

SOCIAL HISTORY:

Marital Status:

- | | |
|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Single | <input type="checkbox"/> Widowed |
| <input type="checkbox"/> Married | <input type="checkbox"/> Divorced |

_____ How many children?

ALCOHOL USE:

- | |
|-------------------------------|
| <input type="checkbox"/> None |
| <input type="checkbox"/> Yes |

How much?

EXERCISE:

- | |
|-------------------------------------|
| <input type="checkbox"/> None |
| <input type="checkbox"/> Type _____ |
| Amount per wk _____ |

DRUG USE: Do you currently use any illegal drugs?

- | | |
|-----------------------------|------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|-----------------------------|------------------------------|

If Yes, please list:

SMOKING STATUS:

Current Smoker

- | | |
|---|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, number of cigarettes per day? _____ | |

Former Smoker

- | | |
|---|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, quit when? _____ | |
| If yes, number of cigarettes per day? _____ | |

Smokeless Tobacco

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

EMPLOYMENT STATUS:

Employed

- | | |
|-----------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If no, why? | |
| <input type="checkbox"/> Laid-off | |
| <input type="checkbox"/> On Leave | |
| <input type="checkbox"/> Retired | |
| <input type="checkbox"/> Disabled | |
| <input type="checkbox"/> Other | |

Job Title

Job Description

- | |
|---------------------------------------|
| <input type="checkbox"/> Not working |
| <input type="checkbox"/> Desk job |
| <input type="checkbox"/> Light labor |
| <input type="checkbox"/> Medium labor |
| <input type="checkbox"/> Heavy labor |

Are you filing for?

- | |
|--|
| <input type="checkbox"/> Disability |
| <input type="checkbox"/> Worker's Comp |
| <input type="checkbox"/> Unemployment |

Are you on?

- | |
|--|
| <input type="checkbox"/> Disability |
| <input type="checkbox"/> Worker's Comp |
| <input type="checkbox"/> Unemployment |

PAST SURGICAL HISTORY: Please check if you have had any of the following surgical procedures:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Lower Back _____ | <input type="checkbox"/> Neck _____ | <input type="checkbox"/> Lung _____ | <input type="checkbox"/> Stomach _____ |
| <input type="checkbox"/> Gall Bladder _____ | <input type="checkbox"/> Heart _____ | <input type="checkbox"/> Uterus/Ovaries _____ | <input type="checkbox"/> Thyroid _____ |
| <input type="checkbox"/> Liver _____ | <input type="checkbox"/> Bowel _____ | <input type="checkbox"/> Prostate _____ | <input type="checkbox"/> Appendix _____ |
| <input type="checkbox"/> Breast _____ | <input type="checkbox"/> Arms/Legs _____ | <input type="checkbox"/> Kidney _____ | <input type="checkbox"/> Hernia _____ |

Other _____ Date _____

Surgeon(s) _____