



FAMILY HISTORY FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

FAMILY HISTORY

Has any family member had:

Table with 6 rows and 6 columns listing medical conditions and their occurrence in the family (Y/N).

PATIENTS MEDICAL HISTORY

Check if you have had any of the following:

- List of medical conditions with checkboxes for patient history: High Blood Pressure, Thyroid Disease, Heart Attack, Arthritis, Reactions to Anesthesia, Nervous Disorders, Smoking, Gonorrhea, Syphilis, Tuberculosis, Blood Disorder, Bleeding Tendency, Migraine Headaches, Pneumonia, Hepatitis, Diabetes, Ulcers, Heart Problems, Seizures, Intolerance to coffee/tea/cola, Vascular Disease/ Claudication.

Other \_\_\_\_\_

Medical problems currently being treated: \_\_\_\_\_

Current medications and dosage: \_\_\_\_\_

List any allergies (include medications): \_\_\_\_\_

- Do you take any Coumadin, Heparin or Aspirin?
Have you ever had a blood transfusion?
Have you ever been exposed to someone with AIDS?

**PREVIOUS SURGERY**

**Type of Surgery**

**Approximate Year**

**Where**

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