Adventist Health Physicians Network

MEDICAL HISTORY OF PATIENT

Name: _____ **Date of birth:** _____

Approx. Height: _____ **Approx. Weight:** _____

DO YOU NOW HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

1. ANEMIA OR BLEEDING PROBLEMS_____ **YES** ☐ **I NO** ☐
2. BLOOD CLOTS_____ **YES** ☐ **I NO** ☐
3. CANCER - SPECIFY LOCATION_____ **YES** ☐ **I NO** ☐
4. DIABETES_____ **YES** ☐ **I NO** ☐
5. EYE PROBLEMS - SPECIFY KIND_____ **YES** ☐ **I NO** ☐
6. HEART DISEASE OR HEART ATTACK – SPECIFY_____ **YES** ☐ **I NO** ☐
7. HEPATITIS OR LIVER DISEASE_____ **YES** ☐ **I NO** ☐
8. HIGH BLOOD PRESSURE_____ **YES** ☐ **I NO** ☐
9. HIV OR AIDS_____ **YES** ☐ **I NO** ☐
10. LUNG DISEASE_____ **YES** ☐ **I NO** ☐
11. MENTAL OR EMOTIONAL PROBLEMS – SPECIFY_____ **YES** ☐ **I NO** ☐
12. NOSE OR SINUS PROBLEMS_____ **YES** ☐ **I NO** ☐
13. SEIZURES OR BRAIN PROBLEMS – SPECIFY_____ **YES** ☐ **I NO** ☐
14. SKIN DISEASE – SPECIFY_____ **YES** ☐ **I NO** ☐
15. THYROID PROBLEMS – SPECIFY_____ **YES** ☐ **I NO** ☐
16. FAMILY HISTORY OF CANCER/BLOOD DISORDER_____ **YES** ☐ **I NO** ☐
17. HISTORY OF SMOKING_____ **YES** ☐ **I NO** ☐
    # of years _____ Cigarettes per day _____
18. ALCOHOL INTAKE_____ **YES** ☐ **I NO** ☐
    Average # of drinks per week _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

ALLERGIES:
