

Brief History Form

Last Name:	First:	Age:	Sex:	Doctor Notes <i>please do not write in this area</i>
Presenting Problem or Proposed Surgery:				
ILLNESS/INJURY: Please check if you have ever had:				
Yes	No	Yes	No	
	High blood pressure		Kidney Stones	
	Diabetes		Abdominal bleeding	
	Peptic ulcers		Diverticulosis	
	Heart attack		Thyroid problem	
	Chest pain/ tightness		Lung problems/ asthma	
	History of heart murmur		Shortness of breath	
	Stroke		Accidents/ broken bones (list)	
	Cancer			
	Hepatitis			
	Yellow jaundice			
	Gallstones			
OPERATIONS: List names and dates of all operations you have had <input type="checkbox"/> None				
Year	Name of Operation	Type of Anesthetic, if Known	Complications	
Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____				
List any hospital admissions or medical conditions not list above:				
FEMALES ONLY: Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No				
DRUGS: Please list all drugs you take and their dosages. <input type="checkbox"/> None				
Drug	Dosage	Drug	Dosage	
ALLERGIES: Please list type and reaction <input type="checkbox"/> None				
Name of Drug	Reaction	Name of Drug	Reaction	
Do you now use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No Day # Yrs ____ / ____				
Have you ever used tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No Yrs Quit _____				
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Day # Yrs ____ / ____				
Have you ever used alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Yrs Quit _____				
Type: _____				
The above information is true and accurate.				
Patient Signature (parent if patient is a minor) _____				