



**PATIENT HISTORY FORM** (continued)

**DO YOU HAVE ANY OF THESE PROBLEMS?** (check yes or no)

- | YES                      | NO                       |                              | YES                      | NO                       |   |
|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea and vomiting          | <input type="checkbox"/> | <input type="checkbox"/> | Black tarry stools                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever and chills             | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Night sweats                 | <input type="checkbox"/> | <input type="checkbox"/> | Unsteady on your feet                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting                     | <input type="checkbox"/> | <input type="checkbox"/> | Seizures  |
| <input type="checkbox"/> | <input type="checkbox"/> | Rashes or other skin changes | <input type="checkbox"/> | <input type="checkbox"/> | Easy bleeding or anemia                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight loss without dieting  | <input type="checkbox"/> | <input type="checkbox"/> | Changes in sleep                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain                   | <input type="checkbox"/> | <input type="checkbox"/> | Decrease in ability to concentrate              |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath          | <input type="checkbox"/> | <input type="checkbox"/> | Excessively thirsty and unable to quench thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Wheezing                     | <input type="checkbox"/> | <input type="checkbox"/> | Depressed mood                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Bowel/bladder incontinence   |                          |                          |   |

**MEDICATIONS** (List below or  check this box if attaching a list of medications)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you currently take a blood thinning medication (e.g. Coumadin/Warfarin/Plavix)?  No  Yes

Do you currently take a low-dose Aspirin (325 mg or less) per day?  No  Yes

**ALLERGIES TO MEDICATIONS:**  No  Yes (List): \_\_\_\_\_

\_\_\_\_\_

**SURGERIES** (List below or  check this box if attaching a list of surgeries)

Date: \_\_\_\_\_ Type of surgery: \_\_\_\_\_

Date: \_\_\_\_\_ Type of surgery: \_\_\_\_\_

Date: \_\_\_\_\_ Type of surgery: \_\_\_\_\_

Date: \_\_\_\_\_ Type of surgery: \_\_\_\_\_

**FAMILY HISTORY** (Check all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Bleeding disorder    | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Neurological disease | <input type="checkbox"/> Diabetes      |

**TYPE OF EMPLOYMENT:** \_\_\_\_\_

- Disabled  Retired  Student

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date