PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. **Please Type or Print.**

NAME: _____ **DATE OF BIRTH**: _____

How did you hear about Dr. Gartside?:_____

PURPOSE FOR VISIT: What is the main reason you are seeing the doctor today?

MEDICATIONS

Please list any medications ***including aspirin, vitamins, over-the-counter, or herbal medication***?		
Medication Name	***Dose***	***How Often Taken***

ALLERGIES TO MEDICINES, ETC

Medication Name	***Type of Reaction***
Do you have environmental Allergies?	☐**Yes** ☐**No** Please list:
Do you have a known allergy to Latex?	☐**Yes** ☐**No**

	Yes	**No**	**Year**	**Comment**
CANCER (please list type):	❒	❒		
Cardiovascular				
Do you have a pacemaker	❒	❒		
High/Elevated Cholesterol	❒	❒		
High Blood Pressure	❒	❒		
Other Heart Problems	❒	❒		
Respiratory				
Asthma	❒	❒		
COPD	❒	❒		
Tuberculosis	❒	❒		
Urologic				
Blood in urine	❒	❒		
Difficulty starting urine stream	❒	❒		
Burning	❒	❒		
Leaking of urine	❒	❒		
Gastrointestinal				
Hepatitis	❒	❒		
Reflux	❒	❒		
Stomach ulcers	❒	❒		
Hematologic/Immunity				
Anemia	❒	❒		
HIV/AIDS	❒	❒		
	❒	❒		

Bleeding after surgery ❒ ❒ Blood transfusion ❒ ❒ Blood Clots/Pulmonary Embolus			
Mental and Emotional Depression (requiring treatment) ❒ ❒ Anxiety (requiring treatment) ❒ ❒			
Other Not Listed Above Problem: ❒ ❒ Diabetes: ❒ ❒ Thyroid: ❒ ❒			

PAST SURGICAL HISTORY

Year	Procedure	Surgeon

Have you ever been hospitalized for any other reasons? ☐**Yes** ☐**No**

If Yes, Please explain:_____

_____

_____

Have you ever had any wound healing issues as a result of a previous surgical procedure? ☐**Yes** ☐**No**

Have you ever been diagnosed with MSRA? ☐**Yes** ☐**No**

FAMILY HISTORY ***Please mark all that apply:***

	Yes	No	Please indicate which family member:
Specific Anesthesia problem	❒	❒	
CANCER (please list type) under check mark	❒	❒	
Cardiovascular & Respiratory:			
High Blood Pressure	❒	❒	
Heart Problems	❒	❒	
Asthma	❒	❒	
Lung Cancer	❒	❒	
Neurologic:			
Stroke	❒	❒	
Hematologic			
Bleeding/clotting problem	❒	❒	

SOCIAL HISTORY

Have you ever smoked? ☐**Yes** ☐**No**	**Comments:**
Do you smoke now? ☐**Yes** ☐**No**	
Do you drink alcohol? ☐**Yes** ☐**No**	**How many per week?**
Do you use any recreational drugs? ☐**Yes** ☐**No**	

Signature: _____ **Date:** _____