MEDICAL HISTORY (PAGE 2)

Name: _____ Date: _____
First Middle Initial Last

PERSONAL PAST MEDICAL HISTORY: Have you ever had:

HIV?	☐ Yes	☐ No				
Abnormal bleeding?	☐ Yes	☐ No	Chest Pains? ☐ No Yes ☐ Explain:			_____
Asthma?	☐ Yes	☐ No	Sleep apnea?	☐ Yes	☐ No	
Acid reflux?	☐ Yes	☐ No	Hypertension?	☐ Yes	☐ No	_____
Anemia?	☐ Yes	☐ No	Hepatitis?	☐ Yes	☐ No	
Blood clots?	☐ Yes	☐ No	Heart attack?	☐ Yes	☐ No	_____
Fainting spells?	☐ Yes	☐ No	Stroke?	☐ Yes	☐ No	
Diabetes?	☐ Yes	☐ No	Thyroid disease?	☐ Yes	☐ No	_____
Kidney disease?	☐ Yes	☐ No	MRSA?	☐ Yes	☐ No	
Pacemaker?	☐ Yes	☐ No	VRE?	☐ Yes	☐ No	_____
Joint replacement?	☐ Yes	☐ No	Tuberculosis?	☐ Yes	☐ No	
Latex allergy?	☐ Yes	☐ No	C-diff?	☐ Yes	☐ No	_____
Oxygen?	☐ Yes	☐ No	Mitral valve prolapse?	☐ Yes	☐ No	
Cancer?	☐ Yes	☐ No	Type of cancer:			_____

Other significant health issues? _____

_____

Do you need pre-operative antibiotics? _____

PAST SURGERIES:

Date:	Type:	Hospital:	Surgeon:

Have you had complications or bad reactions to anesthesia? ☐Yes ☐No

List: _____

Have you ever had a transfusion? ☐Yes ☐No If so, when? _____

Have you had a significant weight change in the last year? ☐Yes ☐No If so, indicate: gain ____lbs or loss ____lbs

Number of pregnancies? ____ Number of children? ____

Do you smoke? ☐No ☐Yes, how much: _____ Do you drink alcohol? ☐No ☐Yes, how much: _____

FAMILY HISTORY

Have any of these illnesses occurred in your family? Check all that apply and indicate relationship to you:

Illness	Relationship to you	Illness	Relationship to you
high blood pressure	_____	ovarian cancer	_____
diabetes	_____	colon cancer	_____
heart disease	_____	skin cancer	_____
breast cancer	_____	type of skin cancer	_____
other	_____	other	_____

Form completed by _____ Relationship to patient _____
(patient's signature) (write self if you are the patient)

Nurse Signature_____ Physician Signature_____

The SHAW Center / Lawrence W. Shaw, MD

Medical History

Name: _____ Date: _____
First Middle Initial Last

Birth date: _____ Age: _____ Height: _____ Weight: _____

Parent(s) and/or Guardian(s): _____

Referring Dr: _____ Family Dr.: _____

Address: _____ Address: _____

Reason for Visit: _____

_____

Have you seen another doctor for this? Who and when? _____

Injury related? ☐ Yes ☐ No Job related? ☐ Yes ☐ No Date of Injury: _____ Symptoms Onset: _____

ALLERGIES

Latex Allergies? ☐ Yes ☐ No Blood Test to Confirm? ☐ Yes ☐ No

Environmental? ☐ Yes ☐ No List: _____

Tape Allergies? ☐ Yes ☐ No List: _____

Drug Allergies? ☐ Yes ☐ No List: _____

Food Allergies? ☐ Yes ☐ No List: _____

List all drug allergies and type of reaction: _____

_____

MEDICATIONS (Attach list if more than ten prescription medications)

Rx: _____ Rx: _____

Rx: _____ Rx: _____

Rx: _____ Rx: _____

Rx: _____ Rx: _____

Rx: _____ Rx: _____

Do you take insulin? ☐ Yes ☐ No Coumadin, Plavix, etc.? ☐ Yes ☐ No Home Oxygen? ☐ Yes ☐ No

(Daily) Aspirin? ☐ Yes ☐ No (Daily) Ibuprofen? ☐ Yes ☐ No Steroids? ☐ Yes ☐ No Vitamins? ☐ Yes ☐ No

Other OTC Supplements? ☐ Yes ☐ No List: _____

Any metal implants/devices? ☐ Yes ☐ No List: _____

For any prescription that this office would need to call in for you, what is the name, telephone number and address of your preferred pharmacy? _____

_____