

MEDICAL HISTORY (PAGE 2)

Name: _____
First Middle Initial Last

Date: _____

PERSONAL PAST MEDICAL HISTORY: Have you ever had:

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

Relationship to patient _____
(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? _____