

HEALTH HISTORY FORM - PFSH

DOB: _____ M / F Height: _____ Weight: _____ BMI: _____ R / L Handed Occupation: _____

Do you have any **ALLERGIES** or **REACTIONS** to **Latex, Iodine** or any **Medication**? ___ **YES**, (please list) or ___ **NO**, I have none of these allergies.

- | | | |
|----|----|----|
| 1. | 3. | 5. |
| 2. | 4. | 6. |

List all **MEDICATIONS/Herbs/Vitamins and Supplements** that you are **currently taking**:

- ☐ Check Box if separate list has been provided
- | | | |
|----|----|----|
| 1. | 3. | 6. |
| 2. | 4. | 7. |
| | 5. | 8. |

List all **SURGERIES** that you have had **with approximate dates** of each surgery:

- | | | |
|----|----|----|
| 1. | 3. | 5. |
| 2. | 4. | 6. |

MEDICAL HISTORY

	NO	YES		NO	YES
High Blood Pressure	___	___	Asthma/Emphysema	___	___
Heart Attack/Coronary Artery Disease	___	___	Bleeding Disorder/Anemia	___	___
Irregular Heart Beat	___	___	If yes, do you have a Pacemaker ? Yes / No	___	___
Stroke/Paralysis	___	___	Intestinal Bleeding/Ulcer	___	___
Diabetes	___	___	Hypothyroid	___	___
Kidney Failure/Disease	___	___	Hyperthyroid	___	___
Rheumatologic Condition	___	___	If yes, are you on Dialysis ? Yes / No	___	___
Hepatitis/Liver Disease/HIV	___	___	Seizures	___	___
MRSA	___	___	TB	___	___
Cancer	___	___	Reaction to Anesthesia	___	___
			Other: _____	___	___
			If yes, Type of Cancer /Description: _____		

FAMILY HISTORY

	NO	YES		NO	YES		NO	YES
Stroke	___	___	Heart Attack	___	___	Diabetes	___	___
			Reaction to Anesthesia	___	___	Bleeding Disorder or Anemia	___	___
			Cancer	___	___	Type: _____		

SYSTEMS REVIEW - Have you **recently** had problems with any of the following?

	NO	YES	DESCRIPTION (If Yes, provide a description and indicate if condition is resolved)
Cold/Flu	___	___	_____
Eye/Ear	___	___	_____
Intestinal	___	___	_____
Heart	___	___	_____
Breathing	___	___	_____
Skin	___	___	_____
Nerve	___	___	_____
Urinary	___	___	_____
Bleeding	___	___	_____
Depression/Anxiety	___	___	_____

SOCIAL HISTORY

Do you **SMOKE**? ___ **NEVER DID** or ___ **QUIT**, I have not smoked since: _____ or ___ **YES**, I smoke _____ cigarettes per day

Do you use **RECREATIONAL DRUGS** (including Marijuana)? ___ **NO** or ___ **YES**

Do you drink **ALCOHOL**? ___ **NO** or ___ **YES**, number of drinks per day _____, week _____, month _____

What sport(s) do you participate in or activities do you do for **EXERCISE**? _____

High School Attended: _____ College Attended: _____