PATIENT MEDICAL HISTORY

Name___________________________________Today's date_____________________

What is the reason for your visit today?____

Please indicate below if you have or have had any of the following conditions:

[ ] Bronchitis	[ ] Cancer	[ ] Pregnancy (#)
[ ] Emphysema	[ ] Stomach/bowel problems	[ ] Stroke
[ ] Asthma	[ ] Seizures, Epilepsy	[ ] Back problems
[ ] Hayfever	[ ] Blood transfusion	[ ] Broken bones
[ ] Sinusitis	[ ] High blood pressure	[ ] Liver disease
[ ] Tuberculosis	[ ] Heart attack	[ ] Blood clots
[ ] Abnormal chest x-ray	[ ] Heart murmur	[ ] Hearing loss
[ ] Congestive heart failure	[ ] Hepatitis	[ ] Fainting
[ ] Shortness of breath	[ ] Chest pain	[ ] Kidney disease
[ ] Cold (last 2 weeks)	[ ] Abnormal bleeding	[ ] Visual problems
[ ] Anemia	[ ] Abnormal ECG	[ ] Diabetes

Cigarette smoker? Yes [ ] No [ ] Packs per day?________ Number of years_________

Previous smoker? Yes [ ] No [ ] Number of years________Quit when?_____________

Alcohol consumption ___________drinks per day / week / month / year.

Please list all previous surgeries____

Do you currently use a CPAP machine?_______________________________________

Could you be pregnant now or planning on becoming pregnant? Yes [ ] No [ ]

Do you have any other medical conditions that Dr. Hardy should be aware of?

If yes, fill in here____

Medications you currently take: ____

Drug Allergies (if none, please write none):_____________________________________

Height: ________________ Weight: __________________