AdventHealth Ottawa

PATIENT HISTORY FORM

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Patient Name: _____ **Age:** _____ **DOB:** _____

What is the reason for your visit today? _____

PAST MEDICAL HISTORY

Please mark any of your current/prior medical problems:

❑ Diabetes	❑ High Blood Pressure	❑ High Cholesterol	❑ Cancer – Type: _____
❑ Stroke	❑ Heart Attack	❑ Emphysema/COPD	❑ Alcoholism
❑ Drug Problem	❑ Depression	❑ Arthritis	❑ Thyroid Disease
❑ Anemia	❑ Mental Health Problems	❑ Asthma	❑ Liver Disease
❑ Allergies	❑ Glaucoma	❑ Tuberculosis/Positive Skin Test	

Please list any other medical history, including pregnancies: _____

_____

Please list prior surgeries: _____ _____

_____

Allergies to medications/food/latex: _____

_____

Please list medication you take (including over the counter medication and vitamins): _____

_____

_____

_____

SOCIAL HISTORY

Marital Status: _____ **Number of Children:** _____ **Occupation:** _____

Hobbies/Activities: _____

Exercise: _____

Do you smoke cigarettes/use tobacco products? ❑ Yes ❑ No

How Often: _____ _____ For how many years? _____

Do you drink alcohol? ❑ Yes ❑ No

How Often: _____ _____ For how many years? _____