



Patient Medical History

Past Medical History (Year: _____)

Physician _____

Address _____

Phone _____

Past Medical History (Year: _____)

Physician _____

Address _____

Phone _____

Previous Hospitalizations & Surgeries

Reason/Surgery _____

Hospital Name _____

Address _____

Physician/Surgeons _____

Reason/Surgery _____

Hospital Name _____

Address _____

Physician/Surgeons _____

Circle those that apply:

- Glaucoma, Cataracts
- Asthma, TB, Pneumonia, Emphysema, Shortness of Breath, COPD,
Other Lung problems: _____
- Rheumatic Fever, Hypertension, Congestive Heart Failure, Heart Attack, Heart Rhythm problems,
Other Heart problems: _____
- Anemia, Bleeding Disorders, Sickle Cell illness,
Other blood problems: _____
- Seizures, Stroke, TIA, Epilepsy, Paralysis,
Other Brain and Nervous System problems: _____
- Ulcers, Diverticular disease, Hernia, Hepatitis, Gallbladder disorders,
Other Stomach, Intestinal or Liver disorders: _____
- Kidney, Urinary Tract Infections, Prostate problems, STDS, Pregnant,
Other Kidney or GYN problems: _____
- Arthritis, Osteoporosis, Back Injury,
Other Bone or Muscle problems: _____
- Diabetes, Thyroid disorders, Mental Illness, Depression, Schizophrenia, Bi-Polar, Cancer,
Other Endocrine disorders: _____
- Implanted Devices: Venous Access, Pacemaker, ALCD, Protacath
- Diet History: Special Diets _____ Low Salt Low fat

Advanced Directives / Organ Donor / Patients Rights and Responsibilities

- Does patient have an Advanced Directive? Yes No
If Yes, what type? _____
 - If No, Offered Advanced Directive Information to: Patient Family
– Response: Accepted Refused
 - Is a copy the Directive in patient's Chart? Yes No
 - If a copy of the Directive is not in patient's Chart, was it requested? Yes No
- Other Questions or Further Information requested?**
- _____
- _____