Beth Israel Deaconess HealthCare®

Patient History Form

Patient Name: Date of Birth:

Marital Status: Married Widowed Separated Divorced Single

Height: Weight:

Employment Status:

Do you have any health concerns presently?

Please indicate whether you have had any of the following:

YES	NO	Anemia or Sickle Cell Disease	HIV Infections/AIDS	YES	NO
YES	NO	Arthritis or Back problems	Heart Attack or Heart Failure	YES	NO
YES	NO	Asthma	Heart Murmur that requires antibiotics before dental work	YES	NO
YES	NO	Bleeding tendencies	Heart Rhythm Abnormalities/Pacemaker	YES	NO
YES	NO	Blood Transfusions	Hepatitis, Liver Disease, or Cirrhosis	YES	NO
YES	NO	Clotting Problems	High Blood Pressure	YES	NO
YES	NO	Bowel Problems	Kidney Disease	YES	NO
YES	NO	Bronchitis, Pneumonia, or TB	Seizures or Epilepsy	YES	NO
YES	NO	Emphysema/COPD	Stomach Ulcers	YES	NO
YES	NO	Cancer, Type	Stroke or Mini-stroke	YES	NO
YES	NO	Chest Pain	Thyroid Abnormalities	YES	NO
YES	NO	Depression	Fibromyalgia	YES	NO
YES	NO	Diabetes	Blood clots/DVT	YES	NO
YES	NO	Elevated Cholesterol		YES	NO

Please list any other medical problems other doctors have diagnosed:

Please list any other doctor or specialist that you are currently seeing:

Name/address of the lab that you currently use for blood work:

Please list the medications you are currently taking:

Medication Name	Strength	Times per Day

Name/address of the pharmacy you use:

Please list any allergies you have to medications, food, etc.:

Allergen	Reaction/Side Effect

Have you ever had an adverse reaction to anesthesia?

Surgical History:

Procedure	Date	Hospital/Doctor

Do you have a Health Care Proxy? Yes No If so, who is it?

Please indicate family medical history:

Medical Condition	Relative	YES	NO
Alcohol/Drug Abuse			
Asthma			
Bleeding Problem			
Cancer, Type			
Depression/Psychiatric Illness			
Diabetes			
Allergies			
Heart Attack			
High Blood Pressure			
High Cholesterol			
Liver Disease			
Kidney Disease			
Anesthetic Problems			
Stroke			
Epilepsy (Seizures)			
Other			

Social History

How many children do you have?

What are their ages?

Who lives at home with you?

Do you use seatbelts consistently?

Do you use a bike helmet regularly?

Do you use sunscreen or protective clothing?

Do you use insect repellant?

Are you a cigarette smoker?

If so, how many packs do you smoke per day?

How many years have you been a smoker?

Are you interested in quitting?

Do you drink alcohol?

If so, how many drinks do you have per week?

Do you drink coffee, tea, and/or caffeinated soda?

If so, how many cups per day?

Do you currently use recreational or street drugs?

Do you exercise regularly?

If so, what exercise and how often?

Are you on a diet?

If so, please describe.

Are you concerned about your weight?

In the past month, have you often:

Felt little interest or pleasure in doing things?

Felt down, depressed, or hopeless?