Dearborn Patient Medical History Form

Name:_____ Date of Birth:_____ Height_____ Weight_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Referred by:_____ Faith Tradition:_____

Occupation:_____ Employer_____ Currently working Yes/No

Primary Care Physician: Full Name:_____Date of last visit:_____

Address:_____

PCP Phone #_____Fax#_____

Are you currently receiving care from any other doctors or health care professionals? (e.g. cardiologist, nephrologist, pulmonologist, oncologist, pain specialist, endocrinologist)

Provider's Name and Specialty Provider's Phone Number

_____ _____

_____ _____

_____ _____

What pharmacy do you use for prescription medications? Please provide name and phone number.

_____

Please list every operation that you have had under anesthesia, including the year, surgeon's name and hospital (if possible):

_____

_____

_____

☐ Yes ☐ No *Do you have allergies to medications, latex, or food?* If yes, please list and state the reaction. _____

☐ Yes ☐ No *Have you taken steroids (Cortisone, Prednisone) in the past? When:*_____

☐ Yes ☐ No *Do you have history of smoking?* How many years did you smoke:_____Year Quit:_____

☐ Yes ☐ No *Do you drink alcohol?* How often:_____Amount:_____

☐ Yes ☐ No *Do you use any recreational or street drugs?*_____

☐ Yes ☐ No *Have you been recently hospitalized?* Reason:_____

☐ Yes ☐ No *Do you use an inhaler?* List drug or type of inhaler used:_____

☐ Yes ☐ No *Do you have a history of depression?*

☐ Yes ☐ No *Have you or any members of your family had problems with anesthesia?*

Please describe:_____

□ Yes □ No *Do you have loose teeth, caps or dentures?*

Please describe:_____

□ Yes □ No *Do you have known Sleep Apnea?*

□ Yes □ No *Do you have a CPAP or BIPAP Machine?*

Please list all of your current prescription /non-prescription medications (you may bring a separate list). Medications include: prescriptions, vitamins, inhalers, supplements, herbal /folk remedies and other non-prescription drugs).

Drug Name	Dose / Amount Taken	Frequency / Time of Day	Reason

Do you now have, or have you ever had, the following medical problems:

(Please circle any that apply)

Heart Attack/ Heart Failure, year_____
History of Congenital Long QT Syndrome
Chest pain, pressure, squeezing
AICD/ Pacemaker **(please bring card)**
Arrhythmia/ Palpitations/ Irregular Heartbeat
Heart Murmur/ Mitral Valve Prolapse
High Cholesterol
Family History of Heart Disease
High/ Low Blood Pressure
Stroke/ Mini Stroke, year_____
COPD/Emphysema
Asthma/ Wheezing
Pneumonia/ Bronchitis/ Chronic Cough
Oxygen Use: flow rate/ route_____
Tuberculosis/ Night Sweats/ Fevers
Cold or Flu within last 2 weeks
Thyroid Disease
Hiatal Hernia/ Ulcers/ Acid Reflux
Cancer (*Do you have a port?* Yes / No)

Diabetes/ Managing Doctor:_____
(Circle Type: Diet Controlled Tablet Insulin)
Kidney Disease: Infection/ Dialysis
Liver Disease: Hepatitis/ Jaundice
Anemia
Blood disorders/ Diseases_____
Transfusion, year_____
Neck/ Back Pain/ Disc Disease
Lupus (SLE)/ Multiple Sclerosis
Polio/ Spinal Cord Injury
Seizures/ Epilepsy
Jaw Problems/ TMJ
Headaches/ Migraines
Physical Disabilities:_____
Male: Prostate Disorder
Female: Use Birth Control Pills
Pregnant
Last Menstrual Period_____
Other:

Family History

Do/did any of your brother, sisters or parents have any of the following:

Rheumatoid Arthritis_____ Heart Attack_____

Other Joint problems_____ Cancer_____

Bleeding problems_____ Diabetes_____

Anesthesia problems_____ Stroke_____

Mental Illness_____ Thyroid Disease_____

Social History

*How many people live in your household (including you)?*_____
*How are they related to you?*_____
Do you have stairs at your home? ☐ Yes ☐ No ☐ Inside ☐ Outside