Kimberly K. Short, M.D.

PATIENT HISTORY

NAME :_____SS#:_____-_____-_____DATE:____/___/____

(Please answer all the questions by circling YES or NO. If necessary, write additional information in the "COMMENTS" section below.)

HT:_____ WT:_____ AGE:_____

HAVE YOU EVER EXPERIENCED OR BEEN TOLD YOU HAVE A HEART, CIRCULATION OR BLOOD PROBLEM?	YES	NO
a. Heart Murmur	YES	NO
b. Mitral Valve Prolapse	YES	NO
c. Heart Attack: Date:_____	YES	NO
d. Irregular Heart Beat	YES	NO
e. High/Low Blood Pressure	YES	NO
f. Stroke or Blood Clots	YES	NO
g. Anemia/Sickle Cell	YES	NO
h. Angina/Chest Pain	YES	NO
I. BLEEDING PROBLEM	YES	NO
j. Excessive Bleeding with a		
-dental procedure	YES	NO
-previous surgery	YES	NO
-menses	YES	NO
k. Other Heart Problems	YES	NO
l. Swollen Legs/Ankles/Joints	YES	NO
m. Rheumatic Fever	YES	NO

DO YOU HAVE OR EVER HAD ANY LUNG OR BREATHING PROBLEMS?	YES	NO
a. Asthma	YES	NO
b. Bronchitis	YES	NO
c. Pneumonia	YES	NO
d. Tuberculosis	YES	NO
e. Chronic Lung Disease	YES	NO
f. Do you cough frequently?	YES	NO
if yes, cough up anything....	YES	NO
G. HAVE YOU EVER SMOKED?	YES	NO
HOW MUCH PER DAY_____		
# OF YEARS_____		
When did you quit?_____		
h. Abnormal Chest X-Ray	YES	NO
I. Shortness of Breath	YES	NO
*at rest___*climbing stairs___*walking brisk___		
j. Have you ever experienced loss of consciousness?	YES	NO

HAVE YOU EVER EXPERIENCED OR BEEN TOLD YOU HAVE DIGESTIVE OR STOMACH/LIVER PROBLEMS?	YES	NO
a. Difficulty Swallowing	YES	NO
b. Hiatal Hernia	YES	NO
c. Gall Bladder Disease	YES	NO
d. Ulcer	YES	NO
e. Jaundice (Yellow Skin)	YES	NO
f. Hepatitis	YES	NO
g. Diarrhea/Constipation/Chg in Stool	YES	NO
h. Weight Loss in Last 4 Months Without Dieting	YES	NO
I. Eat a Special Diet	YES	NO
j. Pancreatitis	YES	NO
k. Vomiting (uncontrollable)	YES	NO
HAVE ANY URINARY, KIDNEY OR BLADDER PROBLEMS?	YES	NO
a. Kidney Stones	YES	NO
b. Frequent Infections	YES	NO
c. Difficult or Painful Urination	YES	NO
d. Unable to Hold Urine	YES	NO
e. Bleeding with urination	YES	NO

DO YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING:		
a. Seizure or Convulsion	YES	NO
b. History of Headaches	YES	NO
c. Arm/Leg Becomes WEAK/NUMB	YES	NO
d. Epilepsy	YES	NO

DO YOU HAVE OR EVER HAD:		
a. Diabetes: If yes, are you	YES	NO
Diet Control_____		
Insulin Control_____		
Oral Medicine Control_____		
b. Hypoglycemic (low sugar)	YES	NO
c. Thyroid Problems	YES	NO

DO YOU HAVE OR EVER HAD:		
a. Physical Limitations or use of aids **(walker, wheelchair, etc.)**	YES	NO
b. Arthritis	YES	NO
c. Difficulty Walking or Lying Flat	YES	NO
d. Back Problems	YES	NO
e. Difficulty Hearing or Speaking	YES	NO

ANY MAJOR ILLNESSES?	YES	NO
Explain:_____		
_____		

ANY VISION PROBLEMS?	YES	NO
Glasses___Contact Lenses___		
Loss of Vision___Glaucoma___		
DENTURES CHIPPED TEETH, BRACES, BRIDGEWORK, PLATES, LOOSE TEETH (circle which applies)	YES	NO

ARE YOU CURRENTLY UNDER THE CARE OF A PSYCHIATRIST OR PSYCHOLOGIST?	YES	NO

(For Women Only) I**S THERE A POSSIBILITY THAT YOU ARE PREGNANT?** Date of last menstrual period_____.	YES	NO

Eating Disorders	YES	NO

(For children under 16) **ARE IMMUNIZATIONS UP TO DATE?**	YES	NO

HAVE YOU EVER HAD A POSITIVE HIV TEST?	YES	NO

LIST ALL MEDICATIONS YOU NOW TAKE. INCLUDE NON-PRESCRIPTION (over the counter) MEDICATIONS.

_____ _____

_____ _____

_____ _____

ARE YOU ALLERGIC TO:

a. Sulfa	YES	NO	d. Codeine	YES	NO
b. Penicillin	YES	NO	e. Demerol	YES	NO
c. Morphine	YES	NO	f. Aspirin	YES	NO

Others:_____

_____

_____

Environment/CONTACT ITEMS (pollen, tape, soaps):_____

_____

DO YOU HAVE ANY SKIN DISORDERS: _____

_____

LIST ALL HOSPITALIZATIONS/OPERATIONS (include any past cosmetic or plastic surgery):

SURGERY:_____**YEAR:**_____ **HOSPITAL:**_____

SURGERY:_____**YEAR:**_____ **HOSPITAL:**_____

SURGERY:_____**YEAR:**_____ **HOSPITAL:**_____

COMPLICATIONS:
Bleeding: YES NO
Healing Poorly YES NO
Other_____
_____
_____

DO YOU CURRENTLY CONSUME ALCOHOL YES NO
HOW MUCH:_____

DO YOU EVER EXPERIENCE DRY EYES: YES NO
How often_____
Medications taken for relief_____

HAVE YOU EVER TAKEN: CORTISONE YES NO
PREDNISONE YES NO
OTHER STEROIDS YES NO

HAVE YOU EVER HAD COMPLICATIONS WITH ANESTHESIA YES NO
If yes, please explain:_____
_____
_____

FAMILY HISTORY:
(Please check those conditions which have occurred in your family)

a. Allergies ___
b. Cardiovascular Disease (heart disease) ___
c. Diabetes ___
d. Pulmonary Disease ___
e. Tuberculosis ___
f. Cancer/Tumors ___
g. Gastrointestinal Disease ___
h. Kidney Disease ___
I. Bone Disease ___
j. Blood Disease ___
k. Congenital Deformities ___
l. Mental Disease ___
m. Thyroid Problems ___
n. Stroke ___
o. Bleeding Tendencies ___
p. Problems with Anesthesia ___

Other:_____

FAMILY HEALTH STATUS:

FAMILY MEMBER (list names)	*AGE*	*GOOD*	*FAIR*	*POOR*	*LIVING OR DECEASED*	*CAUSE OF DEATH*	*KNOWN ILLNESSES*
Mother							
Father							
Children M F 1. M F 2. M F 3. M F 4. M F 5. M F							
Siblings **Sisters:** **1.** **2.** **3.** **4.** **Brothers:** **1.** **2.** **3.** **4.**							

_____ _____
Patient Signature **Date**

_____ _____
Legal Guardian (if not parent) **Date**