



Abbreviated Patient History

Patient Name: _____ Date of Birth: _____ Age: _____
Reason for Visit: _____
Referring Physician: _____

Past Medical Problems:

Past Surgical History:

Medications:

Allergies:

Have you ever had any of the following problems? Check all that apply.

- Bleeding problems related to surgery or dental procedures
- History of sleep apnea
- History of heart attack, stroke, hypertension, swelling in your legs, chest pain, or angina
- History of asthma, bronchitis, emphysema, tuberculosis, or pneumonia
- History of peptic ulcer disease, liver disease, gallbladder problems, colon problems, rectal bleeding, anal fissure/fistula, or hemorrhoids
- History of kidney problems, kidney failure, kidney stones, urinary, or bladder problems
- History of diabetes, thyroid disease, or Hashimoto's disease
- History of headaches or seizure disorders
- History of arthritis, bone problems, or joint problems