Medical, Surgical & Family Health History

Island Health Care

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Patient Medical / Surgical History

Past Medical History: Are you being trWeated or have you ever been treated for the following? (Check all that apply.)

❑ ADHD	❑ Eczema	❑ Nerve/Muscle Disease
❑ Allergic Rhinitis	❑ Emphysema	❑ Obesity
❑ Allergies	❑ GERD	❑ Osteoporosis
❑ Anemia	❑ Glaucoma	❑ Pneumonia
❑ Anxiety	❑ Headache	❑ Scoliosis
❑ Arthritis	❑ Hearing Loss	❑ Seizures
❑ Asthma	❑ Heart Murmur	❑ Sickle Cell Anemia
❑ Cancer	❑ Hepatitis	❑ Stroke
❑ Cataracts	❑ HIV/AIDS	❑ Substance Abuse
❑ CHF	❑ Hypertension	❑ Thyroid Disease
❑ Clotting Disorder	❑ Inflammatory Bowel Disease	❑ Tuberculosis
❑ COPD	❑ Jaundice	❑ Ulcers (GI)
❑ Depression	❑ Kidney Disease	❑ UTI
❑ Diabetes Mellitus	❑ Meningitis	❑ Varicella
❑ Eating Disorder	❑ Myocardial Infarction	❑ Vision Problems
OTHER (Please Explain)		

Past Surgical History: (Check all that apply.)

❑ Adenoidectomy	❑ Fracture Surgery	❑ Prostate Surgery
❑ Appendectomy	❑ Gastrostomy	❑ Small Intestine Surgery
❑ Brain Surgery	❑ Heart Surgery	❑ Spine Surgery
❑ CABG	❑ Hernia Repair	❑ Tonsillectomy
❑ Cholecystectomy	❑ Hysterectomy	❑ Umbilical Hernia
❑ Colon Surgery	❑ Joint Replacement	❑ Valve Replacement
❑ Cosmetic Surgery	❑ Lymph Node Biopsy	❑ Vasectomy
❑ Eye Surgery	❑ Mastectomy	❑ VP Shunt
OTHER (Please Explain)		

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Were you adopted?

❑ Yes ❑ No

Please note the ages and significant health problems for any of these close relatives:

Relative	Age	Significant Health Problem
Mother alive? ❑ Yes ❑ No		
Father alive? ❑ Yes ❑ No		
Sibling alive? **M / F** ❑ Yes ❑ No		
Sibling alive? **M / F** ❑ Yes ❑ No		
Sibling alive? **M / F** ❑ Yes ❑ No		
Sibling alive? **M / F** ❑ Yes ❑ No		
Other relationship alive? **M / F** ❑ Yes ❑ No		