LIGHTHOUSE HEALTHCARE, LLC

Name: ____________________ Date: ______________
Age: _______________ DOB: ______________

Reason for OV: _________________________________

List Previous Surgeries and Hospitalizations

Year Reason
1. _________ _________________________________
2. _________ _________________________________
3. _________ _________________________________
4. _________ _________________________________
5. _________ _________________________________
6. _________ _________________________________

List Medications including Over the Counter

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

List Allergies (Drugs, Other)

1. ____
2. ____
3. ____
4. ____
5. ____

HAVE YOU HAD: CIRCLE

1. Head trouble	YES	NO
2. High blood pressure	YES	NO
3. Asthma	YES	NO
4. Bronchitis, Emphysema, or other lung disease	YES	NO
5. Epilepsy or Seizures	YES	NO
6. Jaundice	YES	NO
7. Hepatitis or Mononucleosis	YES	NO
8. Back trouble	YES	NO
9. Abnormal chest x-ray	YES	NO
10. Abnormal electrocardiogram	YES	NO
11. Glaucoma	YES	NO
12. Abnormal bleeding tendencies	YES	NO
13. Anticoagulant Therapy (blood thinners)	YES	NO
14. Blood disease (anemia, etc.)	YES	NO
15. Kidney disease	YES	NO
16. Fracture of facial bones	YES	NO
17. Fracture of neck or back	YES	NO
18. Muscle weakness	YES	NO
19. Paralysis	YES	NO
20. Blood transfusion	YES	NO
21. Stroke	YES	NO
22. Blood vessel disease (phlebitis)	YES	NO
23. Diabetes	YES	NO
24. Unexplained high fever	YES	NO
25. Other medical illness	___________________	
26. Any infectious disease	___________________	

DO YOU:

Smoke	YES	NO
How many pk/day	__________	
Drink alcoholic beverages	YES	NO
How many drinks/day	__________	
Do you drink coffee/tea/soda	YES	NO
Caffeine free	YES	NO
Object to blood transfusion	YES	NO
Have a Pacemaker	YES	NO
Use recreational drugs	YES	NO

WOMEN ONLY:

Date of last menstrual cycle: _______________
Date of last pap smear: ____________________

Have you had a Mammogram	YES	NO
Are you pregnant	YES	NO
Number of children	__________	

FAMILY HISTORY: Arthritis, Cancer, Diabetes, Epilepsy, Heart Disease, Stroke, High Blood Pressure, Kidney Disease

Relationship	HEALTH PROBLOM: List all that apply	If deceased, Cause & Age
FATHER		
MOTHER		
BROTHER/SISTER		
BROTHER/SISTER		
BROTHER/SISTER		

I certify that the above information is correct to the best of m knowledge. I will not hold my provider or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: ____ Date: ______________________