

JAMES E. CHAPPELL, MD PA

PATIENT MEDICAL HISTORY

Patient Name: _____ Height: _____ Weight: _____

Name of Primary Physician: _____ Physician Telephone No.: _____

Address of Primary Physician: _____

Last Physical Exam: _____ Are You Pregnant? **Yes No** Any Chance of Pregnancy? **Yes No**

Purpose of Today's Visit: _____

Smoking History? **Yes No** Packs per day: _____ How long: _____ Quit? _____ How long ago: _____

Coffee/Caffeine Use? _____ Cups per day: _____ Do You Use Drugs? _____

Do You Drink Alcohol? _____ If Yes, How many drinks per: day _____ week _____ month _____

List any **Drug Allergies** or Sensitivities (list reaction to each): _____

Current Medications (including over the counter medications like Aspirin and Herbs)

NAME and DOSE: _____

Do you take **Aspirin** or Aspirin like products on a Daily basis? _____

Hospitalization and Surgery:

REASON and DATE: _____

Past Medical History (please check all that apply)

Abnormal Bleeding _____ Lung Disease _____

Arthritis _____ Kidney disease _____

Asthma _____ Glaucoma _____

Cancer (if yes type) _____

Diabetes _____ Heart Disease _____

Hepatitis _____ Blood Transfusion _____

Hi Blood Pressure _____ Epilepsy _____

Stroke _____ Stomach Ulcer _____

Thyroid Disease _____ Rheumatic fever _____

Poor Circulation _____ Anxiety/Depression _____

High Cholesterol _____ Psychiatric history _____

Breast Cancer/Disease _____ (if YES see below)

Problems with Anesthesia? (If Yes Describe) _____

Other/Comments: _____

Family History (please check all that apply)

Abnormal Bleeding _____ Lung Disease _____

Arthritis _____ Kidney disease _____

Asthma _____ Glaucoma _____

Cancer (if yes type) _____

Diabetes _____ Heart Disease _____

Hepatitis _____ Blood Transfusion _____

Hi Blood Pressure _____ Epilepsy _____

Stroke _____ Stomach Ulcer _____

Thyroid Disease _____ Rheumatic fever _____

Poor Circulation _____ Anxiety/Depression _____

High Cholesterol _____ Psychiatric History _____

Breast Cancer/Disease _____ (if YES see below)

Problems with Anesthesia? (If Yes Describe) _____

Other/Comments: _____

Breast Patients only: Age of 1st Period _____ No. of Pregnancies/Deliveries _____ Age of Menopause _____

Date of Last Mammogram _____ Where? _____

Family History of Breast Cancer _____ Relationship _____ Age of Diagnosis _____

I CERTIFY THAT ALL OF THE ABOVE ANSWERS ARE TRUE, COMPLETE, AND CORRECT TO THE BEST OF MY KNOWLEDGE

SIGNED: _____

DATE: _____