PATIENT HEALTH HISTORY (Page 1 of 2)

NAME: _____

HEIGHT: _____ WEIGHT: _____ SEX: _____

Name of Family Physician: _____

Please state the reason you are seeing Dr. Marouk: _____

Do you use any form of tobacco: ☐ Yes ☐ No How much?_____ How Long?_____

Are you presently taking any medications? ☐ Yes ☐ No

List Medication Name:	Dosage:	How often taken:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take vitamin, herbal or steroid supplements? ☐ Yes ☐ No

Do you use any medicated skin creams, ointments? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No

Medication Name:	Type of Allergic Reaction Experienced:
_____	_____
_____	_____
_____	_____

Allergic to Shellfish? ☐ Yes ☐ No

Allergic to Iodine? ☐ Yes ☐ No

Do you take aspirin or aspirin products routinely? ☐ Yes ☐ No

Have you ever had a Surgical Procedure? Surgery Type and Date:	Have you ever had Cosmetic Surgery? Surgery Type and Date:
_____	_____
_____	_____
_____	_____

Have you had anesthesia: ☐ Yes ☐ No

Has anyone in your family been diagnosed with Malignant Hyperthermia? ☐ Yes ☐ No

Have you or anyone in your family had any allergic or other reactions to anesthesia? ☐ Yes ☐ No

Date:	Medical Condition Suffered:
_____	_____
_____	_____

Family History: Do you have a family history of any of the following disorders?

☐ Yes ☐ No Breast Cancer	☐ Yes ☐ No Diabetes	☐ Yes ☐ No Lung Disease
☐ Yes ☐ No Bleeding or Blood Disorders	☐ Yes ☐ No Epilepsy	☐ Yes ☐ No Heart Problems
☐ Yes ☐ No Cancer _____	☐ Yes ☐ No Asthma	☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Tuberculosis (T.B.)	☐ Yes ☐ No Stroke	☐ Yes ☐ No Hypertension

PATIENT HEALTH HISTORY (Page 2 of 2)

Have you ever had any of the following problems?

LUNGS (PULMONARY)	YES	NO
Bronchitis		
Emphysema		
Asthma		
Wheezing		
Pneumonia		
Tuberculosis (T.B.)		
Chronic or Frequent Cough		
Shortness of Breath		
Abnormal Chest X-Ray		
Any Lung Disease		
Chronic Nose/Sinus Cmplts.		

HEMATOLOGIC	YES	NO
Blood Clots in Your Legs		
Pulmonary Embolism		
Phlebitis		
Varicose Veins		
Easy Bleeding Tendency		
Easy Bruising Tendency		
Blood Clotting Abnormalities		
Blood or Plasma Transfusion		
Hemophilia		
Recurrent Nosebleeds		

GASTROINTESTINAL	YES	NO
Jaundice or Hepatitis		
Liver Disease		
Stomach Ulcers		
Frequent Heartburn		
Hernia		

RENAL	YES	NO
Kidney Disease/Stones		
Frequent Bladder Infections		
Prostate Problems		

SKIN	YES	NO
Have you had Skin Cancer?		
Chronic Skin Condition Ex: Hives, Eczema, Rashes?		
Form Large Scars/Keloids		
ACTH/Steroid Medication		
Allergic to Suture Materials		
Frequent Infections/Boils		

NEUROLOGICAL	YES	NO
Stroke		
Fainting Spells		
Convulsions		
Seizures		
Epilepsy		

CARDIOVASCULAR	YES	NO
Mitral Valve Prolapse		
Anemia		
High Blood Pressure		
Chest Pain/Angina		
Heart Attack		
Irregular Heartbeats		
Congestive Heart Failure		
Rheumatic Fever		
Heart Murmurs		
Heart Block		
Low Potassium		
Abnormal EKG		
Pacemaker		
Any Heart Disease		
Sickle Cell Disease		

MUSCULOSKELETAL	YES	NO
Chronic Back Pain		
Chronic Neck Pain		
Arthritis		
Bone, Joint, Muscle Trouble		

METABOLIC	YES	NO
Recent Unexpected Weight loss		
Diabetes		
Thyroid/Goiter Problems		
Night Sweats/Fever		
AIDS (HIV+)		

VISION	YES	NO
Glaucoma		
Loss of vision		
Radial Keratomy		
Wear Glasses		
Wear Contacts		

MENTAL	YES	NO
Do you have, or have had emotional problems?		
Any recent emotional crisis?		

PREGNANCY	YES	NO
Any possibility you are Pregnant?		
Have you had a tubal ligation or hysterectomy?		

MAMMOGRAM	YES	NO
Have you had a mammogram?		
When?		

Patient Signature _____ Date _____