Daniela J. Schupp MD PhD, PLLC Personal Health History

Patient's Name:____________________________________ **Today's Date:**_______________

Patient's Date of Birth:__________/_____________/_______________

Medication Allergies (including iodine/contrast/latex) **and Reactions**:

______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________

Medication List

List all current medications, including over the counter drugs, such as vitamins and inhalers.

Medication	Dose	Frequency

Past Medical History: (check all that apply)

_Acid Reflux/GERD	_Alzheimers: dementia	_Anemia	_Anorexia nervosa
_Anxiety	_Arthritis:type	_Asthma	_Atrial Fibrillation
_Autoimmune Disease	_Back Pain	_BPH/Prostate	_Bleeding Disorder
_Bronchitis	_Breast Mass	_Bulemia	_Cancer: Breast
_Cancer: Colon	_Cancer:other specify	_COPD	_Celiac Disease
_Colonoscopy; date	_Congestive Heart Failure	_Coronary Artery Disease	_Crohn's Disease
_Deep Venous Thrombosis	_Depression	_Diabetes	_Diverticulosis/itis
_EGD; date	_Emphysema	_Echocardiogram; date	_Exercise Stress Test
_Gallstones	_Gout	_Headaches;Migraines	_Hearing Loss
_Heart Attacks: when	_Heart Murmurs	_Hemorrhoids	_Hepatitis
_Hernias	_High Cholesterol	_History of MRSA	_HIV
_Home Oxygen/CPAP	_Hypertension	_Hyperthryoidism	_Hyopthyroidism
_Jaundice	_Kidney Disease	_Kidney Stones	_Liver Disease/Cirrhosis
_Malignant Hypertension	_Menopause	_Neuropathy	_Osteoporosis

_ Pancreatitis	_Peptic Ulcer Disease	_Problems with Anesthesia	_Pulmonary Embolism
_Seizures;Epilepsy	_Sleep Apnea	_Stroke:when	_Ulcerative Colitis

Any other disease you may have that you think we should know about?____________________

Family history (please indicate which family member (FM: mother/father/sister/brother/paternal from your father's side "p" grandfather/grandmother, aunt/uncle/cousin, maternal from your mother's side "m" grandmother/grandfather, aunt/uncle/cousin)

Alcohol/Substance Abuse:	FM____________________	Alzheimer's/Dementia:FM__________________
Arthritis:	FM______________________	Asthma: FM_____________________________
Breast Cancer:	FM______________________	Cancer/specify type:FM___________________
Colon Cancer:	FM______________________	Diabetes: FM ___________________________
Emphysema:	FM______________________	Gallbladder Disease:FM_________________
Heart Attack (MI):	FM______________________	Heart Problems: FM___________________
Hernia	FM______________________	High Cholesterol: FM__________________
Hypertension	FM______________________	Kidney Disease: FM___________________
Lung Cancer	FM______________________	Malignant Hypertension: FM_____________
Obesity	FM______________________	Ovarian Cancer:FM_____________________
Pancreatic Cancer	FM______________________	Prostate Cancer: FM__________________
Skin Cancer	FM______________________	Stroke: FM____________________________
Unknown	________________________	Unremarkable__________________________

Past Surgical History: (check all that apply)

_Appendix	_Back Surgery	_Bariatric Surgery	_Breast Surgery
_CABG	_C-Section	_Cancer Surgery	_Cataract Surgery
_Gallbladder	_Heart Surgery	_Hemorrhoidectomy	_Hernia Repair
_Hip Replacement	_Hysterectomy	_Knee Replacement	_Knee Surgery
_Lumpectomy/Breast	_Mastectomy	_Other	_Other
_Prostate Surgery	_Rectal/Colon	_Testicular Surgery	_Thyroid Surgery
_Tonsillectomy	_Tubal Ligation	_Vasetomy	

Social History (please fill in, mark or circle)

Occupation (if retired, please list former):____

Retired? Yes/No How Many Biological Children?:__________ Adopted Children?____________

Smoking Status (circle one): Never/Former/Current

Smoking How Much?_____________________ Since Age?____________________________

Chewing Tobacco (circle one): None/1 per day/2-4 per day/> 5 Vaping (circle one): Yes/No

Alcohol Intake (circle one): None/Rarely/Occasional/Weekly/Daily Type: Beer/Wine/Hard Liquor

Marijuana (circle one): None/Occasional/Weekly/Daily How much/in what form?:_____________

Illicit Drugs (circle one): Never/In the Past/Current What type?____________________________

Who Do You Live With?____

Do You Have Support in this Town/Driver to and from the Hospital?:________________________

Advanced Directive (circle one): Yes/No (circle one): Full code/Partial Code/DNR