

Baum 5 Star Healthcare

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MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____

Today's Date: _____

DO YOU CURRENTLY HAVE OR HAVE HAD A HISTORY OF THE FOLLOWING?

- | | | | | |
|--|---|---------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> Diabetes: with use of <input type="checkbox"/> Pills <input type="checkbox"/> Insulin | <input type="checkbox"/> High Blood pressure/Hypertension | | | |
| <input type="checkbox"/> High Cholesterol/Hyperlipidemia | <input type="checkbox"/> Hypothyroidism | | | |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Atrial Fibrillation | | | |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Depression/Anxiety | | | |
| <input type="checkbox"/> Obstructive sleep apnea | <input type="checkbox"/> Fibromyalgia | | | |
| <input type="checkbox"/> Congestive Heart failure/CHF | <input type="checkbox"/> Asthma | | | |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Migraines/headaches | | | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> GERD/reflux | | | |
| <input type="checkbox"/> Stroke/CVA – any residual weakness | <input type="checkbox"/> Cirrhosis | | | |
| <input type="checkbox"/> Hepatitis: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Valley Fever/Coccidioidomycosis | | | |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Arthritis | | | |
| <input type="checkbox"/> Cancer (If so, check the box that applies to your type of cancer) | | | | |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Lung | <input type="checkbox"/> Kidney | <input type="checkbox"/> Bone | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Uterine | <input type="checkbox"/> Breast | <input type="checkbox"/> Bladder | <input type="checkbox"/> Ovarian |

SURGERIES/DATES:

- | | |
|--|---|
| <input type="checkbox"/> Pacemaker/Defibrillator: _____ | <input type="checkbox"/> Tonsils removed/Tonsillectomy: _____ |
| <input type="checkbox"/> Adenoids removed/Adenoidectomy: _____ | <input type="checkbox"/> Appendix removed/Appendectomy: _____ |
| <input type="checkbox"/> Gallbladder removed/Cholecystectomy: _____ | <input type="checkbox"/> Abdominal surgery: _____ |
| <input type="checkbox"/> Gastric Sleeve: _____ | <input type="checkbox"/> Gastric Bypass: _____ |
| <input type="checkbox"/> Prostate Removal/Prostatectomy _____ | <input type="checkbox"/> Cervical spine surgery: _____ |
| <input type="checkbox"/> Thoracic spine surgery: _____ | <input type="checkbox"/> Lumbar spine surgery: _____ |
| <input type="checkbox"/> Shoulder surgery- left/right _____ | <input type="checkbox"/> Wrist surgery- left/right _____ |
| <input type="checkbox"/> Finger surgery – left/right: _____ | <input type="checkbox"/> Hip surgery – left/right: _____ |
| <input type="checkbox"/> Knee surgery – left/right: _____ | <input type="checkbox"/> Ankle surgery – left/right: _____ |
| <input type="checkbox"/> Foot surgery – left/right _____ | <input type="checkbox"/> Toe surgery – left right: _____ |
| <input type="checkbox"/> Ovaries removed/oophorectomy _____ | <input type="checkbox"/> Uterus removed/Hysterectomy: _____ |
| <input type="checkbox"/> C-section _____ | <input type="checkbox"/> CABG: _____ |
| <input type="checkbox"/> Any other surgeries not listed above: _____ | |

