Name:_____ **Date:**_____

PATIENT CONFIDENTIAL MEDICAL HISTORY FORM

Scott P. Leary, M.D.

Please answer ALL questions. If you do not understand the question or know the answer, write "?" in the space. Use the back of this form if additional space is needed to list your answers.

Nature of Complaints:_____

General Health

Height: _____ **Weight:** _____

Do you smoke? **Y/N/Quit.** If yes, how many packs/day/how long? _____ If you quit, what year?_____

Alcoholic Beverages/Day:_____ Coffees/Day: _____ Teas/Day: _____

Do you have any medication allergies? **Y/N.** If yes, please list:_____

What types of allergic reaction did you have?_____

Past Medical History-Do you have or have you ever had any of the following major illnesses?

Asthma	**Y/N**	COPD/Emphysema	**Y/N**	High Blood Pressure	**Y/N**	Spinal Trauma	**Y/N**	Urinary Tract Infection	**Y/N**
Bleeding Disorder	**Y/N**	Diabetes Type ____	**Y/N**	High Cholesterol	**Y/N**	Stroke	**Y/N**	**Other:**	
_____Cancer	**Y/N**	Heart Disease	**Y/N**	Kidney Disease	**Y/N**	Thyroid Disorder	**Y/N**		

Family History-Do any of your family members have or had any major illnesses? If none, please write none.

Family Member:	**Illness/Condition:**

Surgical History- If none, please write none. Use the back of this form if additional space is needed.

Name of Surgery:	**Name of Surgeon:**	**Date of Operation: (MO/YR)**

Current Medications- If none, please write none. Use the back of this form if additional space is needed.

Name of Medication:	**Dose of Medication (e.g. 10 mg):**	**Frequency (e.g. 1/day):**

Do you take aspirin? **Y/N** Do you take fish oil? **Y/N** Do you take any other types of bloodthinners? **Y/N**

If yes, please list:_____

Do you have or have you ever had:

Abnormal bleeding or anemia	**Y/N**	Difficulty climbing stairs	**Y/N**
Hypertension	**Y/N**	Ulcer or Gastritis	**Y/N**
Weight Loss	**Y/N**	Difficulty swallowing	**Y/N**
Fits/Convulsions/Seizures	**Y/N**	Numbness	**Y/N**
Double vision	**Y/N**	Paralysis	**Y/N**
Sudden vision loss	**Y/N**	Diabetes	**Y/N**
Decreased hearing	**Y/N**	Stroke	**Y/N**
Shortness of breath	**Y/N**	Heart Surgery	**Y/N**
Loss of memory	**Y/N**	Chest Pain	**Y/N**
Mental Illness	**Y/N**	Alcohol/Drug Addiction	**Y/N**
Metal in Body	**Y/N**	Claustrophobia	**Y/N**
Pacemaker or Defibrillator	**Y/N**	Implanted Device or Battery	**Y/N**

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the medical office of any changes in medical status.

Patient (or Legal Guardian) Signature:_____ **Date:** _____