ROBERT C SALTER MSN, CRNP/MICHAEL GAINES MD

PATIENT PAST MEDICAL HISTORY FORM CHART# _____

NAME: _____AGE:_____ DOB: _____ DATE: _____

PRIMARY CARE PHYSICIAN: _____PRIMARY PHARMACY:_____

REASON YOU ARE HERE: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?

CIRCLE AND GIVE DATES:

Heart Attack _____ Asthma _____ Arthritis _____ Heart Failure _____ Emphysema _____ Unplanned weight loss _____
Heart Disease _____ TB _____ Enlarged lymph nodes _____
High Blood Pressure _____ Pneumonia, severe _____ Blood Thinner _____
Poor Circulation _____ Hiatal Hernia _____ Severe Heart Burn _____
High Cholesterol _____ Stomach Ulcers _____ Hepatitis _____
Stroke _____ Jaundice _____ Kidney Infection _____ Kidney issues _____
Severe Headaches _____ Thyroid Problems _____ Diabetes _____
Seizures _____ Blackout Spells _____ Head Injury _____ Meningitis _____
OTHER PROBLEMS NOT LISTED _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:
PENECILLIN _____ SULFA _____ ASPIRIN _____ CODEINE _____ TETANUS _____
DEMEROL _____ "MYCINS" _____ OTHER _____
PLEASE LIST ANY SURGERIES:

SURGERY	DATE	HOSPITAL	SURGEON

CIRCLE THE FOLLOWING THAT APPLY:
SINGLE MARRIED DIVORCED WIDOWED SMOKE? DRINK ALCOHOL?
FAMILY HISTORY-CIRCLE THAT APPLY:
HEART DISEASE DIABETES HIGH BLOOD PRESSURE CANCER STROKE
MOTHER LIVING? _____
FATHER LIVING? _____
LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING:
_____
_____