Dr. Keith's WELLNESS OPTIONS

GENERAL PATIENT HEALTH HISTORY

1. Name: _____ **Birthdate:** _____

2. Describe your daily physical activity: _____

_____

3. Do you currently:

- ❑ **Smoke:** NO YES _____ Packs/Day
- ❑ **Drink Alcoholic beverages** NO YES Daily Occasionally
- ❑ **Use drugs, example: marijuana etc.** NO YES Please describe _____

4. Medication Allergies with reactions (Please List)

_____ _____

_____ _____

5. Current Medicines you take or use and dosages: (Please list)

_____ _____

_____ _____

_____ _____

6. Have you had: (Please check those that apply)

Cardiovascular Problems

- ❑ Heart Attack
- ❑ Angina
- ❑ High Blood Pressure
- ❑ Blood Clots
- ❑ Heart Surgery
- ❑ Clogged Arteries
- ❑ Abnormal EKG

Gastrointestinal:

- ❑ Ulcers
- ❑ Gallbladder Disease
- ❑ Liver Disease
- ❑ Hepatitis
- ❑ Jaundice
- ❑ Hemorrhoids

Lung Problems:

- ❑ Asthma
- ❑ Emphysema
- ❑ Abnormal Chest X-Ray
- ❑ Lung Surgery
- ❑ T.B

Neuro-psychiatric:

- ❑ Paralysis
- ❑ Seizures
- ❑ Stroke
- ❑ Bipolar

Skeletal:

- ❑ Broken Bones
- ❑ Back Injuries
- ❑ Neck Injuries

Endocrine:

- ❑ Diabetes
- ❑ Thyroid
- ❑ Adrenal

Other:

- ❑ Bleeding Tendencies
- ❑ Anesthesia Reaction
- ❑ Blood Transfusion Reaction
- ❑ Cancer of any type

Type:_____

7. Surgical History(Please list date of surgery if known)

_____Appendectomy
_____Breast surgery
_____Colon or intestinal surgery
_____Gallbladder
_____Heart Attack
_____Hiatal Hernia
_____Hernia, Inguinal
_____Hernia, Umbilical
_____Hernia, Ventral

_____Lung
_____Thyroid
_____Tonsillectomy
_____Ulcers (Stomach)
_____Hystertectomy (Uterus removed only)
_____Ovaries
_____Tubal Ligation
_____Prostate

Other:_____