

**Patient History Sheet**

**David V. Spurlin, MD**

Date: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_ Sex:  M  F Cell Phone: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Who referred you to this office? \_\_\_\_\_  
 Medication Allergies: \_\_\_\_\_  
 Current Medications: \_\_\_\_\_

Do you take aspirin or blood thinners?  Yes  No Do you have artificial joints or heart valves?  Yes  No  
 Do shots or something similar make you faint?  Yes  No Do you take antibiotics before teeth cleanings?  Yes  No  
 Females: Are you pregnant or breast feeding?  Yes  No Are you planning or trying to become pregnant?  Yes  No  
 Have you traveled in the last year to undeveloped area, South America, Africa, or the India Subcontinent?  Yes \_\_\_\_\_  No

**Health Questionnaire:**

Reason for today's visit (CC): \_\_\_\_\_  
 Associated symptoms (circle): irritated itch pain bleeding growing changing  
 What has helped or worsened the condition: \_\_\_\_\_

**Past Medical History:** Please check from the list below or write in current and past medical problems.

- |   |  |  |
|---|--|--|
| Irregular Heart Beat <input type="checkbox"/>   | High Blood Pressure <input type="checkbox"/>     | Stroke <input type="checkbox"/>                    |
| Angina <input type="checkbox"/>                 | Mitral Valve Prolapse <input type="checkbox"/>   | Headache/Migraine <input type="checkbox"/>         |
| Heart Attack <input type="checkbox"/>           | Heart Murmur <input type="checkbox"/>            | Seizures <input type="checkbox"/>                  |
| Heart Transplant <input type="checkbox"/>       | Rheumatic Fever <input type="checkbox"/>         | Vision Problems/Cataracts <input type="checkbox"/> |
| <hr/>   |  |  |
| Diabetes <input type="checkbox"/>               | Asthma <input type="checkbox"/>                  | Hepatitis <input type="checkbox"/>                 |
| Thyroid Disease <input type="checkbox"/>        | Seasonal Allergies <input type="checkbox"/>      | Kidney/Urine Problems <input type="checkbox"/>     |
| Arthritis <input type="checkbox"/>              | Emphysema <input type="checkbox"/>               | Stomach/Ulcer Disease <input type="checkbox"/>     |
| Lupus <input type="checkbox"/>                  | Tuberculosis <input type="checkbox"/>            | _____ <input type="checkbox"/>                     |
| <hr/>   |  |  |
| Skin Cancer <input type="checkbox"/> Type _____ | Other Cancer <input type="checkbox"/> Type _____ |  |

Please List Medical Problems: \_\_\_\_\_

**Family Medical History:**

Mother: living/deceased Age: \_\_\_\_\_ Medical Problems: \_\_\_\_\_  
 Father: living/deceased Age: \_\_\_\_\_ Medical Problems: \_\_\_\_\_  
 Brothers/Sisters: \_\_\_\_\_  
 Children: No. of Children: \_\_\_\_\_ Ages: \_\_\_\_\_

**Social History:**

Do you live alone?  No  Yes Do you smoke?  No  Yes amount per day \_\_\_\_\_  
 Do you drink alcohol?  No  Yes amount per day \_\_\_\_\_ Do you use recreational drugs?  No  Yes-frequency \_\_\_\_\_  
 Hobbies/leisure activities: \_\_\_\_\_

All fees incurred at each office visit are the ultimate responsibility of the patient unless other arrangements are made.  
 I consent to the release of my medical information for treatment, payment and healthcare operations. Thank you.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

**For Minors,** Parent or Guardian consent for future evaluation and treatment is required, if such consent is granted then please sign below:

**Signature of Parent or Guardian:** \_\_\_\_\_