

Health History

Ht: _____' _____" Weight _____ Date of Birth _____

Last Physical Exam: _____ Doctor: _____ Clinic: _____

Reason for seeing Dr. Quardt: _____

Please indicate your Personal Health: _____

Medications: List ALL medications, prescriptions, non-prescriptions, vitamins, and recreations drugs you are currently taking.

Medication/Vitamins	MG	How Often (1x/day)
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-
-
-
-

Name of current Pharmacy: _____ Location/City: _____

Past Medical History Conditions:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chem. Dependency | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Goiter | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Vaginal Infections | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Other: _____ |

Health History

Hospitalizations:

Year Hospital Reason Outcome

Family History:

Relation Age State of Health Age at Death Cause of Death

Father
Mother
Sisters

Prior Surgeries:

Surgery Date Outcome

- Appendectomy
- Back or Neck
- Cesarean
- Cholecystectomy
- Hysterectomy
- Mastectomy
- Orthopedic
- Tonsillectomy

Brothers

Breast Cancer History:

Has anyone in your family had Breast Cancer?

- Mother
- Paternal Grandmother, Mom's Mom
- Maternal Grandmother, Dad's Mom
- Sister
- Aunt

Previous Cosmetic Surgery:

Year Doctor Reason Outcome

Injuries/Illness:

Injury/ Illness Date Outcome

- Yes No Are you subject to excessive bleeding if cut?
- Yes No Have you ever had a blood transfusion?
- Yes No Have you or anyone in your family had an adverse reaction to anesthesia or certain drugs?

Occupational Concerns:

- Stress
- Hazardous Substances
- Heavy Lifting
- Other

Feel free to discuss anything further with Dr. Quardt & staff.

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Quardt or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____