SOUTHEAST KANSAS HEALTHCARE 1505 W. 4th Coffeyville, KS 67337
(620) 251-2400 FAX (620) 251-1619

Patient History Form

Name ______________________ Date __________

Have You Ever Had

1	Diabetes	Yes	No
2	High Blood Pressure	Yes	No
3	Heart Attack	Yes	No
4	Stroke	Yes	No
5	Ulcers	Yes	No
6	Diverticulosis	Yes	No
7	Heart Trouble	Yes	No
8	Heart Murmur	Yes	No
9	Asthma	Yes	No
10	Arthritis	Yes	No
11	Cancer	Yes	No
12	Seizures	Yes	No
13	Cataracts	Yes	No
14	Prostate Trouble	Yes	No
15	Headaches	Yes	No

Medications

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Allergies

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Surgeries

1	Appendectomy	Yes	No
2	Tubal / Vasectomy	Yes	No
3	Hysterectomy	Yes	No
4	Gallbladder	Yes	No
5	Prostate	Yes	No
6	Heart	Yes	No
7	Breast	Yes	No
8	Hip / Knee	Yes	No
9	Hernia	Yes	No
10	Stomach	Yes	No
11	Colon	Yes	No
12	Tonsils	Yes	No

Do You Smoke? Yes No

Have You Ever Smoked? Yes No

Packs Per Day __________

How Many Years? __________

Do You Drink? Yes No

How Much? __________

Your Occupation __________

Do Any Blood Relatives Have

1	High Blood Pressure	Yes	No
2	Heart Trouble	Yes	No
3	Stroke	Yes	No
4	Ulcers	Yes	No
5	Breast Cancer	Yes	No
6	Colon Cancer	Yes	No
7	Diabetes	Yes	No
8	Prostate Trouble	Yes	No
9	Seizures	Yes	No
10	Alzheimer's	Yes	No
11	Migraines	Yes	No

Comments:

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