UNIVERSITY Pain Clinic

NEW PATIENT MEDICAL HISTORY FORM

Medical History: (Check all that apply to YOU past and present)

_____ Hypertension	_____ Hypotension	_____ Stroke
_____ Heart disease	_____ Bowel/bladder problems	_____ Ulcers
_____ Asthma	_____ Depression	_____ Hepatitis
_____ Diabetes	_____ Bleeding disorder	_____ Sinus
_____ Cancer (list below)	_____ Lung disease	_____ Thyroid
_____ Elevated cholesterol	_____ Immunodeficiency	_____ Seizures
_____ Anemia	_____ Liver disease	_____ Angina
_____ Other (list below)	_____ Edema	_____ Stomach pain

Other: _____

_____

Surgical History (List **all** surgeries you have had): _____

_____

Do you take any "blood thinners": _____ NO _____ YES – please list _____

Known Drug Allergies: _____

Known Food Allergies: _____

Known Latex Allergy: _____ NO _____ YES – what happens? _____

Do you have (or recently had): (Check all that apply)

_____ Headaches	_____ Chronic cough	_____ Weight loss
_____ Bruise easily	_____ Swelling	_____ Fever/Chills
_____ Sleeping difficulty	_____ Dizziness	_____ Weight gain
_____ Urine incontinence	_____ Fatigue	_____ Weakness
_____ Tremors	_____ Anxiety	_____ Hopelessness
_____ Diarrhea	_____ Constipation	_____ Memory loss
_____ Other (list below)	_____ Sexual dysfunction	_____ Depression

Do you Smoke? _____ NO _____ YES – how much? _____

Do you drink alcoholic beverages? _____ NO _____ YES – how much? _____

Do you use any "street drugs"? _____ NO _____ YES – what/when? _____