HONORHEALTH®

Patient Label

MEDICAL HISTORY

Name: _____ Date of Birth: _____ Today's Date: _____

Do you currently have or have you had in the past any of the following:

	Y	N		Y	N		Y	N
Pacemaker/Defibrillator			Balance Problems			Depression		
Breathing/Respiratory Problems			Incontinence-Bowel/ Bladder problems			Swelling in extremities		
						Polio		
Back Trouble			Eye Problems			Stroke/TIAs		
Diabetes			Headaches			Osteoporosis		
Cancer			Blood Clots/DVTs			Dizziness		
High Blood Pressure			Anemia			Epilepsy/Seizures		
Low Blood Pressure			Supplemental Oxygen			Ear Trouble		
Musculoskeletal Problems			Speech/Language Problems			Infection/Unhealed Wounds		
Chest Pain			Kidney Problems			Wear Orthotics		
Cardiac/Heart Problems			Nausea/Vomiting			Skin Disease		
Broken bones/Fractures			Arthritis			Smoke		
Stomach Trouble			Location: _____			PPD _____ Years _____		
Swallowing Problems			Tuberculosis			Voice Problems		

Please explain all YES answers: _____

_____

_____

_____

Please List Significant Diagnoses, Conditions, or Major Injuries:

1. _____ 2. _____

3. _____ 4. _____

Please List any Surgeries with dates:

1. _____ 2. _____

3. _____ 4. _____

Do you have eating or swallowing difficulties? ☐ Yes ☐ No If yes, describe: _____

_____

Do you have speech, language, voice, or cognitive problems? ☐ Yes ☐ No If yes, please describe: _____

_____

_____

Please list all medications you are taking, including all prescription, over-the-counter, and herbal.

1. _____ For what: _____ How often taken: _____

2. _____ For what: _____ How often taken: _____

3. _____ For what: _____ How often taken: _____

4. _____ For what: _____ How often taken: _____

5. _____ For what: _____ How often taken: _____

6. _____ For what: _____ How often taken: _____

7. _____ For what: _____ How often taken: _____

8. _____ For what: _____ How often taken: _____

9. _____ For what: _____ How often taken: _____

Do you have any allergies, including drug allergies? ☐ Yes ☐ No To what and how does it effect you: _____

Is there a possibility that you are pregnant? ☐ Yes ☐ No

Do you have an advanced directive/living will? ☐ Yes ☐ No
Please explain your resuscitation specifications: _____

Is there anything else that we should know? _____

_____

Patient's Signature: _____ Date: _____