Washington Township Medical Foundation
Part of Washington Hospital Healthcare System

NAME: _____ DATE: _____/_____/20_____

PATIENT HISTORY

Requesting/Primary Doctor _____

What is the reason or condition that brings you to our office?

_____

_____

_____

List all of your medical conditions (i.e. diabetes, heart attack, hypertension, stroke, etc):

_____

_____

_____

List all prior surgeries (include date, facility, and surgeon):

_____

_____

_____

List all medications and dose (aspirin products, herbal, prescription, over the counter, vitamins, etc.):

_____

_____

_____

Allergies to medications? Y N ⇒ Please list: _____
Allergies to IV dyes/x-ray contrast? Y N ⇒ Shellfish or iodine: Y N
Do you smoke tobacco products? Y N ⇒ Packs per day x years: _____
Are you an ex-smoker? Y N ⇒ Packs per day x years: _____
Do you drink alcohol? Y N ⇒ Quantity per week: _____
Occupation: _____ Marital Status: S M D W

Significant family medical history? _____
Do you require antibiotic prophylaxis prior to medical/dental procedures? Y N
If so, list the medical condition(s): _____
Family history of kidney disease? Y N ⇒ Kidney stones? Y N
Family history of prostate cancer? Y N ⇒ Bladder cancer? Y N

Date of last menstrual cycle: _____/_____/_____ Number of pregnancies: _____
Number of vaginal deliveries? _____ Cesarean sections? _____