Past Medical History

Titanium HEALTHCARE

Have you ever been told you have any of the following health conditions? Please check **YES** or **NO.**

Health conditions	NO	YES	If yes, please explain
Diabetes			☐ Type I ☐ Type II
High Blood Pressure			
Irregular Health Rhythm			
Heart Failure			
Heart Attack			
Blood Clots			
Kidney Disease			
Liver Disease			
High Cholesterol			
Anxiety			
Depression			
Stroke			
Thyroid Disease			
Cancer			
Arthritis			
Anemia			
Lung Disease			
COPD			
Asthma			

Devices / grafts	NO	YES	If yes, please explain and include the year
IDC (Implanted Cardiac Defibrillation)			
Cardiac Stents			
Vascular Stents			
Artificial Joints			

PAST SURGERY AND HOSPITALIZATIONS

Please tell us about any surgeries or hospitalizations.

Surgeries	Year	Hospitalizations	Year

SOCIAL HISTORY

Tell us about your social history. Please check **YES** or **NO.** If **YES**, please fill out details below:

Social history	NO	YES	Start date	Stop date	Current	Daily amount
Tobacco Use						
Alcohol Use						
Illicit Drug Use						
Do you drink caffeine?						
Do you drink tea?						

FAMILY HISTORY

Have any of your family members been diagnosed with any of the following conditions? If **YES**, please explain.

Family history	NO	YES	If yes, please explain which relative and include the year they were diagnosed
Cancer			
Hypertension			
Diabetes			
Heart Disease			
Other			
Other			
Other			

MEDICATIONS

Tell us about your current medications.

MEDICATION NAME	Strength	Route	Regimen	Start date	End date	Refills needed?

ALLERGIES

Are you allergic to any medication? If so, which one and please explain what type of allergic reaction you experience.

Medication name	Explain allergic reaction e.g. Hives, Rash etc...

HEALTH CARE MAINTENANCE AND IMMUNIZATIONS

Please tell us about your routine tests / screenings and immunizations.

Tests / screenings	NO	YES	Month/Year
Flexible Sigmoidoscopy			
Mammogram			
Pap Smear			
Heart Disease			
Bone Density			
Stress Test			
Other			
Other			
Other			
Immunizations	**NO**	**YES**	**Month/Year**
Pneumonia			
Shingles			
Tuberculosis			
Flu			
T-Dap			
Tetanus			
Gardasil			

PATIENT'S NAME

PATIENT'S SIGNATURE

DATE

PATIENT'S LEGAL REPRESENTATIVE *(if different than patient)*

DATE