PANDORA E. CHRISTIE, MD

MEDICAL HISTORY UPDATE **Date:_____**

PatientName: _____Age:_____Wt:_____Sex:_____ DOB:_____

Primary Care Physician: _____Address:_____

Are you presently in good health? □ ☐YES ☐ NO

Past Serious Illness? _____

If yes, please explain: _____

Are you being treated for any illness? □ ☐YES ☐ NO

If yes, please explain: _____

List all medications which you are taking (including OTC & herbals) : _____

Allergies to medications? ☐ YES ☐ NO

Please List: _____

Allergies to Food: ☐ YES ☐ NO

Please List: _____

Is there any chance you are pregnant? ☐ YES ☐ NO

Have you ever had a blood transfusion? ☐ YES ☐ NO

List all operations in the past: _____

Any reaction to anesthesia? □ ☐ YES ☐ NO

Do you use tobacco products? □ ☐YES ☐ NO □ in the past?

If yes, please list how much and how long: _____

Do you drink alcoholic beverages? ☐□ YES ☐□ NO

If yes, please list how much and how long: _____ ____

PANDORA E. CHRISTIE, MD

MEDICAL HISTORY UPDATE

Patient Name:_____Date:_____

Do you have a past history of:	**YES**	**NO**
Sinus infections	☐	☐
Ear infections	☐	☐
Headaches	☐	☐
Glaucoma	☐	☐
High blood pressure	☐	☐
Bleeding disorders	☐	☐
Heart problems	☐	☐
Hay fever	☐	☐
Lung problems	☐	☐
Hearing problems	☐	☐
Ulcers	☐	☐
Snoring	☐	☐
Mouth breathing	☐	☐
Reproductive disorders	☐	☐
Psychiatric problems	☐	☐
Street drug use	☐	☐
Emotional problems	☐	☐
Frequent infections	☐	☐
Eczema	☐	☐
Hives	☐	☐
Thyroid problems	☐	☐
Circulatory problems	☐	☐

Family history of: **Cancer** ☐ **Diabetes** ☐ **Heart disease** ☐

Hay fever ☐ **Asthma** ☐ **Eczema** ☐

Thyroid disease ☐