Cross Island Medical Center

Phone: 843-681-8260
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157 William Hilton Parkway
Hilton Head Island, SC 29926

MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: ____/____/____ Sex: M F

List any allergies:_____

Have you ever had dental or local anesthesia? Yes No Any bad reactions? Yes No

List all medications you are currently taking (including over-the-counter meds, vitamins, and herbals):

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please circle YES or NO)

Lungs:		
Bronchitis	Yes	No
Emphysema	Yes	No
Asthma	Yes	No
Chronic cough	Yes	No
Morning cough	Yes	No
Shortness of breath	Yes	No
Wheezing	Yes	No
Cardiovascular:		
High Blood Pressure	Yes	No
Chest Pain	Yes	No
Heart Attack	Yes	No
Heart Murmur	Yes	No
Irregular Heartbeat	Yes	No
Phlebitis:	Yes	No
Inflammation of vein	Yes	No
Blood Clots	Yes	No
Pacemaker	Yes	No

Other Systemic::		
Diabetes	Yes	No
Excessive Thirst	Yes	No
Amputation	Yes	No
Thyroid	Yes	No
Kidney	Yes	No
Dialysis	Yes	No
Bladder	Yes	No
Frequency/burning	Yes	No
Gastrointestinal	Yes	No
Stomach absorptive disorder	Yes	No
Nausea, vomiting, diarrhea when taking antibiotics	Yes	No
Yeast infection when taking antibiotics	Yes	No
Arthritis/Joint		
Deformity	Yes	No
Arthralgia	Yes	No
Limited motion	Yes	No
Artificial Joint	Yes	No
Convulsions, Epilepsy		
Seizures	Yes	No
Fainting	Yes	No

List any other diseases or conditions:

_____

List any surgeries you have had:

_____

Social history:

Do you drink alcohol? Yes No Socially Do you use IV drugs? Yes No

Do you smoke? Yes No If yes how much? _____

Are you immune suppressed? Yes No Women, Are you currently pregnant? Yes No

Patient Signature_____ Date _____/_____/_____