



Benjamin J. Boudreaux, M.D.

Patient History Sheet

Name: _____ Date: _____

Phone Number: _____ Referring Physician _____

Reason for today's office visit: _____

Currently are you experiencing any of the following symptoms?

Severe headaches	Y	N	Chronic cough	Y	N
Ringing in the ears	Y	N	Shortness of breath	Y	N
Dizziness	Y	N	Fever	Y	N
Fainting Spells	Y	N	Severe indigestion	Y	N
Blind Spells	Y	N	Jaundice	Y	N
Chest pain	Y	N	Diarrhea	Y	N
Breast pain, discharge or masses	Y	N	Rectal Bleeding	Y	N
Spitting up blood	Y	N	Bleeding tendencies	Y	N

OTHER ILLNESSES YOU NOW HAVE (If Any)

YOUR PRESENT WEIGHT _____ HEIGHT _____

MEDICATIONS: include dose

Prescription Drugs

Non Prescription (Vitamins; Herbs)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Regular Aspirin Use: Y N Dosage & frequency: _____

NSA (Advil, Motrin, Ibuprofen): Y N Dosage & frequency: _____

Cortisone Injections Past Year: Y N Date(s) and injection location: _____

Are you allergic to:

Penicillin Y N Codeine Y N

Sulfa Y N Tetanus Y N

"Mycin" Y N Demerol Y N

Aspirin Y N Other _____

Latex Allergy: Y N Tape Allergy: Y N

SOCIAL

Age: _____ Sex: M F Married: Y N Occupation: _____

Responsible Adult Available to Assist During Recovery Period Y N Relationship: _____

HABITS

Smoke: Y N Amount: _____ Coffee/Tea/Cola: Y N Amount: _____

Alcohol: Y N Amount: _____ Daily Exercise: Y N Amount: _____

HAVE YOU EVER HAD (Please Circle if Yes) Not circling is considered a "No" Answer.

- | | | |
|---------------------|----------------------|---------------------|
| Free Bleeding | Lung Trouble | Rectal Trouble |
| Heart Trouble | Asthma | Hemorrhoids |
| Chest Pain | Emphysema | Rectal Bleeding |
| Angina Pectoris | Chronic Cough | Chronic Diarrhea |
| High Blood Pressure | Spitting Up Blood | Varicose Veins |
| Stroke | Thyroid trouble | Leg Swelling |
| Paralysis | Back Ache (Severe) | Poor Circulation |
| Severe Headaches | Severe indigestion | Diabetes |
| Seizures | Gallbladder Trouble | Tobacco Use |
| Ringing in Ears | Hepatitis | History Tobacco Use |
| Dizziness | Yellow Jaundice | Alcohol Use |
| Blind Spells | Stomach Ulcer | History Alcohol Use |
| Fainting Spells | Kidney Problems | Drug Abuse |
| Anemia (Low Blood) | Urinary Problems | Prostate Problems |
| Blood Thinner | Urine Leakage | Female Trouble |
| Blood Transfusion | Difficulty Urinating | Infertility |
| Cancer | Bright's Disease | Sexual Problems |

Have you ever received a transfusion? Y N If yes, what year? _____

Have you been tested for HIV? Y N If yes, what year _____ Test results: positive negative

Do you wear: Contact lenses: Y N Eye glasses: Y N Hearing aid: Y N Dentures: Y N

ANY BLOOD RELATIVE HAD: If Yes - Who

- | | | | | | | | |
|---------------------|---|---|-------|------------------------|---|---|-------|
| Seizure Disorder: | Y | N | _____ | Mental Illness | Y | N | _____ |
| Cancer : | Y | N | _____ | Suicide | Y | N | _____ |
| Tuberculosis: | Y | N | _____ | Congenital Deformities | Y | N | _____ |
| Diabetes: | Y | N | _____ | Kidney Trouble | Y | N | _____ |
| Heart Trouble | Y | N | _____ | Kidney Stones | Y | N | _____ |
| High Blood Pressure | Y | N | _____ | Bladder Trouble | Y | N | _____ |
| Stroke | Y | N | _____ | Inheritable Disease | Y | N | _____ |

LIST ANY OPERATION YOU HAVE HAD

Operation	Date	Surgeon	Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Indicate the type(s) of anesthesia received in the past, list any complications / reactions you experienced:

- o Local anesthesia - (complications/reactions): _____
- o General anesthesia -(complications/reactions): _____
- o Spinal Epidural - (complications/reactions): _____

Date last seen by Primary Care Physician: _____

Primary Care Physician (name) _____ (telephone) (_____) _____
 (address) _____

WOMEN PATIENTS ONLY:

Are you pregnant or suspect you may be pregnant? Y N

Number of pregnancies _____ Number of children _____ Last menstrual period _____ Did you breast feed? Yes No

Name: _____ **Date:** _____

Patient's signature, parent or guardian if patient is a minor