

**MIGUEL A. DELGADO, JR., M.D., F.A.C.S.  
HEALTH HISTORY REPORT**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

**MEDICAL PROBLEMS:**

	<u>Yes / No</u>		<u>Yes / No</u>		<u>Yes / No</u>
High Blood Pressure	€ €	Hepatitis	€ €	Heart Attack	€ €
Diabetes	€ €	Thyroid Problems	€ €	Stroke	€ €
Asthma	€ €	Lung Disease/Problems	€ €	Cancer	€ €
HIV Positive	€ €				

**HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ (lbs.) **HIP:** \_\_\_\_\_ (in.) **WAIST:** \_\_\_\_\_ (in.) **BUST:** \_\_\_\_\_ (in.)

**OPERATIONS:** Please list all surgeries:

DATE OF SURGERY:	PROCEDURE:	ANESTHETIC:	COMPLICATIONS:

**MEDICATIONS:** Please list all medications you are presently taking:

MEDICATION:	DOSAGE:

**ALLERGIES:** Please list all allergies:

MEDICATION:	REACTION:

**FAMILY HISTORY:** \_\_\_\_\_

**HABITS:**

Do you or have you ever smoked? € YES € NO      If **yes**, please provide

details: \_\_\_\_\_

Do you drink alcohol? € YES € NO      If **yes**, please provide details: \_\_\_\_\_

**SOCIAL HISTORY:**

Type of Work: \_\_\_\_\_ Marital Status: \_\_\_\_\_ # of Children: \_\_\_\_\_

**REVIEW OF SYMPTOMS:** Do you presently have any of the following conditions:

<i>Respiratory:</i>	
<i>Urinary Tract</i>	
<i>Symptoms:</i>	
<i>Chest Pains:</i>	
<i>Shortness of Breath:</i>	
<i>Additional Information:</i>	

**I certify that the information I have provided Dr. Delgado with is true and accurate.**

\_\_\_\_\_  
Patient Signature (or parent/guardian if patient is a minor)

\_\_\_\_\_  
Date