## Robert M. West, D.O.

## **PATIENT MEDICAL HISTORY**

PLEASE PRINT:										
HIS	STOF	RY OF SURGERY(S) OR H	OSPIT	ALI	ZATIONS:					
								<del></del>		
ME	MEDICAL HISTORY:									
Have you, or any members of your family had any of the following? Please put an "X" in the box that applies:										
SELF / FAMILY MEMBER			SELF / FAMILY MEMBER				SELF / FAMILY MEMBER			
		Anemia			Epilepsy / Seizures			Heart Problems		
		Blood Disorder			Hay Fever / Sinus Problems			High Blood Pressure		
		Hepatitis			High Cholesterol			Stroke		
		Bleeding / Bruising			Depression			Lung Disease		
		Diabetes			Emotional Problems			Thyroid Disease		
		Asthma			Drug / Alcohol Dependency			Kidney Disease		
		Bronchitis			Arthritis			Liver Disease		
		Emphysema			Immune Disorders			Skin Disease		
PA	TIE	NT SOCIAL HISTORY:								
Alcohol Use:										
Tobacco Use:										
Substance Abuse:   Never   Type / Frequency										
Environmental Exposure:   □ Dust □ Fumes □ Solvents List all:										
Patient Signature							Date			
Legal guardian if other than patient							<del></del>			