Dr. Matthew Hagan
Health History & Physical

Name____ **Date**__________________________

Reason for appointment:____

Referral Source:___________________________ **Ads in Post Register IF Magazine Airport Internet**

Height: _____________ **Weight:** ______________ **Date of Birth:** _______________ **Age:** ___________

Current occupation: _______________________________________ **Marriage Status:**__________________

City of Residence:__________________ **# of Full Term Births:** _____ **Age of Youngest Living Child:** ____

Do you have any upcoming important events?____

Personal History of Any of the Following Health Problems?

Yes	No		Yes	No		Yes	No	
□	□	Asthma	□	□	Bleeding Disorder	□	□	Thyroid Disease
□	□	Kidney Disease	□	□	Tumor, Cancer	□	□	Glaucoma/Porphyria
□	□	Diabetes	□	□	Seizures, Convulsions	□	□	Anesthesia problems
□	□	Hiatal Hernia/Reflux	□	□	Current/Recent Pregnancy	□	□	Psychiatric Disorder
□	□	High Blood Pressure	□	□	Malignant Hyperthermia	□	□	Do you smoke?
□	□	Heart Disease	□	□	HIV/Hepatitis	□	□	Rheumatoid Arthritis
□	□	Anemia	□	□	Lung/Breathing Problems	□	□	Blood Clots/Swollen Legs
□	□	Recent use of Steroids/Prednisone						
□	□	Any Other health problems________________________						

ALLERGIES TO MEDICATIONS: ____

Please list **ALL** Medications you are currently taking below, or attach a copy:

____
____
____
____
____

Please list surgical history below (date and type of surgery)

____
____
____
____
____

Family History: Has anyone in your family had any of the following? (Blood relatives such Father, Mother, Siblings)

Yes	No		Yes	No	
□	□	Diabetes	□	□	Bleeding problems (clots or hemophelia)
□	□	Breast Cancer	□	□	Heart Disease

Following to be completed by Doctor or Nurse:

Diabetes______**Recent Steroids**______**Blood Clots**______**Bleeding**______**Smoking**______