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

Name:_____Age:_____DOB:_____Sex:_____

MEDICAL PROBLEMS:

	Yes / No		Yes / No		Yes / No
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:

Respiratory:	
Urinary Tract Symptoms:	
Chest Pains:	
Shortness of Breath:	
Additional Information:	

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