Medical History

This information is for use by your physician as part of your confidential medical record **Date ___/___/___**

Name ____________________________ Best Phone # To Contact You ______________ Age ____ Birth Date _____/_____/_____

Primary Care Physician Name ____________________ Group/Address ______________________________ Phone ______________

MEDICATIONS (Prescription, Over-The-Counter, Vitamins, Herbs, etc.)

DRUG NAME	DOSE	DRUG NAME	DOSE

ALLERGIES TO MEDICATIONS OR OTHER SUBSTANCES ☐ Yes ☐ No If Yes, please list medications and type of reaction

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PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS **Please check if you have <u>ever</u> had any problems with or are presently experiencing any of the following:**

- ☐ Arthritis
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Eyes, Ears, Nose or Throat Problems
- ☐ Stomach Problems
- ☐ Female Problems
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney/Bladder Problems
- ☐ Liver Problems, Hepatitis
- ☐ Lung Problems
- ☐ Musculoskeletal
- ☐ Neurological Problems (stroke, seizures…)
- ☐ Psychiatric
- ☐ Sexually Transmitted Diseases
- ☐ Skin Problems
- ☐ Thyroid Problems
- ☐ Other ______________________

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PLEASE LIST AND SUPPLY DATES OF ALL SURGERIES:

Surgery	Date

SOCIAL HISTORY

Do you currently smoke? ☐ Yes ☐ No If yes, how many packs per day? ____________________ Have you ever smoked? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how much per week? ____

Do you use drugs (marijuana, cocaine, crack, etc.) ☐ Yes ☐ No If yes, please explain: ___________________________________

Method of birth control (if used)? ____

FAMILY HISTORY Has any member of your family (parents, siblings, grandparents, children, aunts and uncles) ever had the following?

ILLNESS	WHICH FAMILY MEMBER(S)?
Cancer (describe type)__________________________	
Hypertension (high blood pressure)	
Heart Disease	
Diabetes	

PREVENTION

Date of Last Flu Shot ______________________________ Have you had the Pneumonia shot and if so when? ______________________

Date of Last Tetanus Shot ____

Signature of Patient or Responsible Party ____