



Patient Medical History Form

NAME: _____ AGE: _____ DATE: _____

PHYSICIAN you were seeing previously: _____

Other SPECIALISTS you currently see: _____

MEDICAL PROBLEMS (including present conditions): _____

List all CURRENT PRESCRIPTION MEDICINES (include dosage, reason you take it, who prescribed it):

List all OVER-THE-COUNTER MEDICINES, vitamins, and food supplements that you take: _____

ALLERGIES TO MEDICATIONS (including reaction): _____

List SURGERIES you have had (include year, surgeon, and hospital): _____

Describe HOSPITALIZATIONS/ILLNESSES not included above (include year, hospital): _____

Have you had (circle):	migraines	hepatitis	mono	ulcer
bleeding problem	blood clots	head injury	drug addiction	gallstones
tuberculosis	STDs	seizures	memory trouble	arthritis
psoriasis	heart murmur	rheumatic fever	polio	shingles
alcoholism	depression	mental illness	gout	hemorrhoids
hearing trouble	vision trouble	other	_____	_____

Ethnicity (circle): Hispanic or Non-Hispanic **Race:** _____ **Preferred Language(s):** _____

Do you have a Living Will? Yes No If Not, are you interested in having one? Yes No

Do/did you SMOKE? Yes No How much? _____ packs/day # of years _____ Year you QUIT _____

When was the last time you tried to quit? _____ How many times have you tried to quit? _____

How have you been successful in quitting in the past? _____

Do/did you DRINK alcohol? _____ How much? _____ drinks/week # of years _____

Year you QUIT _____ Previous or current problem with alcohol? _____ AA? _____

Do you or have you used (circle): heroin marijuana cocaine methamphetamine chewing tobacco diet pills

Do you have a history of prescription drug abuse or addiction? _____ If yes, which one(s)? _____



Patient Medical History Form

WOMEN

Age at first period _____ Date of last normal period _____ # of pregnancies _____

of live births _____ # of children living with you _____ # abortions/miscarriages _____

Problems with pregnancies (circle) pre-term labor toxemia diabetes high blood pressure other: _____

Birth control method _____

Date of last Pap _____ Result? _____ Done where? _____

Date of last mammogram _____ Result? _____ Done where? _____

Do you have (circle):

irregular periods bad menstrual cramps heavy periods abnormal mammogram abnormal Pap smear

pelvic pain infertility sexual difficulty hot flashes vaginal dryness

vaginal discharge vaginal odor vaginal itching PMS breast changes

ALL

Who in your *family* has/had (circle if cause of death and write age of death)

heart disease _____ genetic disorder _____

diabetes _____ cancer (what type?) _____

thyroid disease _____ alcoholism _____

mental illness _____ arthritis _____

glaucoma _____ asthma _____

allergies _____ stomach problems _____

tuberculosis _____ high blood pressure _____

List any other diseases that run in your family and specify your relationship to each family member listed. _____

When was your last:

tetanus shot _____ flu shot _____ pneumonia vaccine _____ hepatitis vaccine _____

TB test _____ colonoscopy _____ chest x-ray _____ EKG _____

Who lives with you? _____

Do you have any children? _____ If yes, list their names, ages, and any major medical problems _____

Where do/did you work? _____ What line of work are you in? _____

What is the last grade in school you finished? _____

Anything else you would like us to know? _____