PATIENT MEDICAL HISTORY

Date: _____

Name: _____

Drug Allergies

_____
_____
_____

Current Meds

_____
_____
_____
_____
_____
_____
_____

Family History

	Father	Mother	Siblings	Children
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐
Convulsions	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐

Hospitalization or Surgery

Date	Reason

Past Medical History

- ☐ Allergies/Hay Fever
- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic rash
- ☐ Chest pains
- ☐ Depresion
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Gout
- ☐ Headache
- ☐ Heart palpations
- ☐ Heart murmur

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ Prostate disease
- ☐ Sexual/Menstrual dysfunction
- ☐ Scarlet Fever
- ☐ Shortness of breath
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Venereal disease

Date of Immunizations:

Hepatitis B:_____ _____ _____

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Bowel irregularity
- ☐ Bloating/Gas
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ Crohns
- ☐ Constipation
- ☐ Gallbladder
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ Pancreatitis
- ☐ Stomach Ulcer

Habits

Smoke now?_____ Coffee: cups daily_____
Ever smoked? _____ Other caffeines _____
Packs daily:_____ Exercise routine: _____
How long_____ Sleep patterns _____
When stopped_____ Fat intake _____
Alcohol: Type/Amt.____ Diet: Salt intake:_____
Contact with blood or body fluids at work?_____
Have you been exposed to toxic chemicals?_____
Explain:_____
_____

For Women Only

Menstruation: First at age:_____. _____days betowwn each period

Period lasts_____ days. Flow is : Light, Moderate, Heavy
Date of last period_____. Pap____ Breast Exam_____
Pregnant? Yes No Planning
Total # of pregnancies_____
Full term delivery_____ Living children_____
Age of youngest_____

Type of Birth control:_____