Medical History

Patient's Name: _____
Date of Birth: _____ Today's Date: _____

Past Medical History

Previous Physician's name: _____ Date of last exam: _____
Have you ever been hospitalized? ☐ Yes ☐ No If yes, what for? _____

Which of the following conditions are you currently being treated or have been treated for in the past? (please check)

☐ Heart disease/Murmur/Angina ☐ High blood pressure ☐ Anemia or blood problems ☐ Stroke
☐ Asthma ☐ Shortness of breath ☐ Lung problems/cough ☐ Sinus problems ☐ Seasonal allergies
☐ Tonsillitis ☐ Ear problems
☐ Liver problems ☐ Heartburn(reflux) ☐ Ulcers/colitis
☐ Headaches/Migraines ☐ Neurological problems
☐ Depression ☐ Anxiety ☐ Psychiatric care
☐ Diabetes ☐ High Cholesterol ☐ Arthritis ☐ Thyroid problems
☐ Eye disorder ☐ Glaucoma

Please describe any current or past medical treatment not listed above

_____
_____

Please list your past surgeries

_____
_____

Are you allergic to any drugs?

_____

Are you currently taking any medications? If so, explain.

_____
_____

Do you currently smoke or chew tobacco? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No
How many packs per day? _____
Do you drink alcohol, beer, or wine? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No
How many drinks per week? _____
Do you currently drink coffee and/or tea? ☐ Yes ☐ No If yes, how many cups per day? _____

Family History

Does anyone of your family suffer or have suffered from any of the following illnesses? If so, please explain.

Anemia or blood disease _____
Cancer _____
Diabetes _____
Glaucoma _____
Heart disease _____
High blood pressure _____
HIV/AIDS _____
Mental Illness/Depression _____
Stroke _____
Other serious illness _____

Females: Gynecological History

Date of last pap smear: _____
Have you had an abnormal pap smear? ☐ Yes ☐ No Diagnosis: _____
Have you had a sexually transmitted disease? ☐ Yes ☐ No Diagnosis: _____
Date of last mammogram: _____
Mammogram results: _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature _____ Date _____