



PATIENT MEDICAL HISTORY

Name: _____ Date: _____

Date of Birth: ___/___/___ Sex: Female / Male

PAST MEDICAL HISTORY - Please list all known medical conditions (past and present)

EXAMPLE: *diabetes*

1 _____ 2 _____ 3 _____ 4 _____ 5 _____	6 _____ 7 _____ 8 _____ 9 _____ 10 _____
---	--

SURGICAL/HOSPITALIZATION HISTORY - Please list all surgeries and hospitalizations.

SURGERY/HOSPITALIZATION
EXAMPLE: *hysterectomy*

DATE
1978

BRIEF EXPLANATION
fibroid tumors were bleeding

1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____

ALLERGY HISTORY - Please list all known medication, food, and environmental allergies.

ALLERGY
EXAMPLE: *penicillin*

REACTION
hives and rash as a child

1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____

MEDICATION HISTORY - Please list ALL medications you are currently taking.

EXAMPLE: *Atenolol 50mg twice daily*

1 _____ 2 _____ 3 _____ 4 _____ 5 _____	6 _____ 7 _____ 8 _____ 9 _____ 10 _____
---	--

NAME _____ DOB: _____

FAMILY HISTORY

Mother: AGE _____ living / deceased / unknown

Medical conditions _____

Father: AGE _____ living / deceased / unknown

Medical conditions _____

Siblings:

AGE(S) _____

Medical conditions _____

Children:

AGE(S) _____

Medical conditions _____

SOCIAL HISTORY

Occupation: _____

Religious preference: _____

Exercise Routine: _____

Which best describes you? (Check one)

_____ SMOKER

Number of packs/day? _____ Number of years? _____

_____ FORMER SMOKER

Number of packs/day? _____ Number of years? _____

When did you quit? _____

_____ NEVER SMOKED

Which best describes your drinking habits? (check one)

_____ NON-DRINKER

_____ RECOVERING ALCOHOLIC quit date _____

_____ RARE ALCOHOL USE

Number of drinks per night? _____ week? _____ month? _____

_____ MODERATE ALCOHOL USE

Number of drinks per night? _____ week? _____ month? _____

_____ SOCIAL ALCOHOL USE

Number of drinks per night? _____ week? _____ month? _____

_____ HEAVY ALCOHOL USE

Number of drinks per night? _____ week? _____ month? _____

Drug Use

Do you use any recreational drugs? Yes / No

Have you ever used or shared needles? Yes / No

NAME _____ DOB: _____

Advance Directive

Advanced Directive? Yes / No *(if Yes, Please provide copy to us)*

Immunizations (list dates):

Hepatitis B:	Influenza:
Td-Adult Tetanus Toxoid:	Pneumonia Shot:
PPD –Tuberculin Skin Test:	Shingles Shot:

Have you been exposed to someone with Tuberculosis? YES / NO

MALES ONLY

Date of most recent PSA blood test _____ / _____ / _____
Date of most recent rectal/prostate examination _____ / _____ / _____

FEMALES ONLY

Date of last menstrual period _____ / _____ / _____
Total number of pregnancies _____
How many were full term deliveries? _____
How many were pre-term deliveries? _____
How many were miscarried/terminated? _____
Date of most recent pap smear _____ / _____ / _____
Have you ever had an abnormal pap smear in the past? YES / NO
Date of last mammogram _____ / _____ / _____
Have you ever had an abnormal mammogram? YES / NO

Please list names of other physicians you see in our area (including specialists):

NOTE: This is a confidential record of your medical history. This information will not be released to any person without your prior written consent.

PROVIDER REVIEWED _____ DATE _____ / _____ / _____