Patient Medical History Form (page 1)

Name: _____ **Date:** _____/_____/_____

Home Ph:_____ Cell Ph: _____ Work Ph: _____

Occupation: _____ Birthdate:___/___/___ Age:____ Gender: □ Male □ Female □ TG

Allergies to Medications, X-Ray Dyes, or other Substances: □ None Use back of page if needed.

Allergy To:	Type of Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications: List Medications, Vitamins, Supplements, Herbs, and Over-the-Counter □ None

Name and Dosage: Use back of page if needed.	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please check if you have a history of :

□ High Blood Pressure	□ Asthma	□ Sleep Problems	□ Indigestion/GERD
□ Diabetes	□ Chronic Lung Disease	□ Snoring	□ Nausea/Vomiting
□ Heart Disease/Failure	□ Chronic Cough	□ Head and Neck Radiation	□ Diarrhea
□ Heart Attack	□ Pneumonia	□ Thyroid Disease	□ Abdominal Pain
□ Heart Valve Disease	□ Bronchitis	□ Osteoporosis/Osteopenia	□ Constipation
□ Atrial Fibrillation (A. Fib)	□ Tuberculosis	□ Low Back Pain	□ Change in Bowel Habits
□ Heart Disease	□ Seasonal Allergies	□ Sciatica	□ Irritable Bowel Syndrome (IBS)
□ Palpitations	□ Urine Infections	□ Arthritis	□ Inflammatory Bowel Disease (IBD)
□ Shortness of Breath	□ Kidney Stones	□ Gout	□ Blood in Stool
□ Swelling of legs/ankles	□ Blood in Urine	□ Skin Rash	□ Ulcers
□ Lightheadedness	□ Incontinence	□ Abnormal Moles	□ Hepatitis/Liver Disease
□ Loss of Consciousness	□ Prostate Disease	□ Skin Cancer	□ Gall Bladder Disease
□ Peripheral Vascular Disease	□ Depression	□ Anemia	□ Diverticulitis
□ Stroke or TIA	□ Anxiety	□ Blood Disorder	□ Hemorrhoids
□ Seizures	□ Alcohol Abuse	□ Cancer	□ Weight Loss
□ Headaches	□ Drug Abuse	□ Sexually Transmitted Disease	□ Erectile Dysfunction

OB/GYN History: Women Only

Last Menstrual Period: _____
Menstrual Frequency: _____
Pregnancies: _____

Post- Menopausal: □ Yes – When?: _____ □ No
Menopausal Symptoms: □ Yes - Type:_____ □ No
Type of Birth Control: _____
Births: _____ Miscarriages: _____

Prolonged or Abnormal Bleeding? □ No □ Yes - Describe: _____
Leakage of Urine ? □ No □ Yes - Describe: _____
History of Abnormal Pap Smear? □ No □ Yes - Describe: _____
History of HPV? □ No □ Yes
History of Sexually Transmitted Disease? □ No □ Yes - Describe: _____

Patient Medical History Form (page 2)

Name: _____ **Date**:

Operations and Hospitalizations: List Year and type of operation or reason for hospitalization

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Immunizations: Year(s)

Tetanus /Diptheria: _____ Flu Shot: _____

Tetanus/Dip/Pertussis: _____ Pneumonia: _____

(Tdap - Includes Whopping Cough)

PPD _____ Hepatitis A (series of 2): _____ / _____

Zoster/Shingles : _____ Hepatitis B (series of 3): ____ / ____ /_____

Screening Tests: Year

Mammogram _____

Breast Exam _____

Pap Smear _____

Dexa Scan _____

Colonoscopy _____

Stool Check for Blood _____

PSA

Family History:

Illness:	GF	GM	F	M	Br	Sis	Child	Age at Onset
Cancer (type):								
High Blood Pressure								
Diabetes								
Heart Disease/Heart Attack								
Stroke								
Psychiatric (anxiety/depression)								
Drug or Alcohol Abuse								
Glaucoma								
Bleeding Diseases								
Other:								

Your Last Dental Visit: _____

Do You:	Yes	No
Wear seat belts?	□	□
Wear a bike helmet?	□	□
Smoke? Amount:	□	□
Drink alcohol? Amount:	□	□
Use drugs? Type:	□	□
Want to be tested for HIV/AIDS	□	□

Your Last Eye Visit: _____

Do you:	Yes	No
Exercise regularly?	□	□
Follow a special diet?	□	□
If yes, type of diet:		
Ever feel afraid of your partner?	□	□
Have a living will?	□	□
Have a donor card?	□	□