PATIENT MEDICAL HISTORY

Today's Date ____________________

Patient Name ______________________________ Date of Birth ____________________

MEDICAL HISTORY – Check all below that apply, and note the year that it started.

	Condition	Year		Condition	Year
❑	**None**	________	❑	Heart Problem	________
❑	Allergy Problem	________	❑	Hepatitis	________
❑	Acid Reflux	________	❑	Headaches	________
❑	Anxiety	________	❑	High Blood Pressure	________
❑	Arthritis	________	❑	High Cholesterol	________
❑	Asthma	________	❑	Kidney Problem	________
❑	Atrial Fibrillation	________	❑	Liver Problem	________
❑	Blood Clots	________	❑	Lung Problem	________
❑	Blood Problem	________	❑	Osteoporosis	________
❑	Cancer	________	❑	Prostate Problem	________
❑	Depression	________	❑	Seizures	________
❑	Diabetes	________	❑	Stroke	________
❑	Gastrointestinal Problem	________	❑	Thyroid Problem	________

❑ Other: ____

____

SURGICAL HISTORY – Check all below that apply, and note the year that is was performed.

	Surgery	Year		Surgery	Year
❑	**None**		❑	Gall Bladder	________
❑	Appendix	________	❑	Hernia	________
❑	Breast Surgery	________	❑	Hip Surgery	________
❑	Cancer surgery	________	❑	Hysterectomy	________
❑	Cataract	________	❑	Knee Surgery	________

HEALTH MAINTENANCE – When did you last have any of the following exams and/or vaccinations?

Exam	Year	Vaccine	Year
Advanced Directive	________	Last Flu Shot	________
Bone Density	________	Pneumovax	________
Colonoscopy	________	Prevnar 13	________
Eye Exam	________	Shingles	________
Mammogram	________	Tetanus	________
Pap / Pelvic Exam	________		
Prostate Exam	________		

PATIENT MEDICAL HISTORY (Page 2)

Today's Date ______________________________

Patient Name ____ Date of Birth __________________________

FAMILY HISTORY – Please check all below that apply. Please list any additional information regarding family history in the "notes" section below.

Diagnosis	Mother	Father	Brother	Sister	Other:
Alcohol Problem	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑
Bleeding Problems	❑	❑	❑	❑	❑
Blood Clots	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑
Dementia / Alzheimers	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑
Lung Problem	❑	❑	❑	❑	❑
Heart Problem	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑
Mental Illness/Suicide	❑	❑	❑	❑	❑
Seizures	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑
Thyroid Problem	❑	❑	❑	❑	❑

Notes:

SOCIAL HISTORY – Check off any that apply.

Do you exercise daily? ❑Yes ❑No If yes, how often? _______________ Type of Exercise: ____________________

Do you drink alcohol? ❑Yes ❑No Amount: _____________ How Often? __________________________________

❑Former Year Quit: ______________

Do you or have you ever smoked tobacco? ❑Current ❑Former ❑Never

Cigarettes/day: ________ Years Used: _________ Year Quit: _________

Do you or have you ever used recreational drugs? ❑Yes ❑No If yes, what have you used? _______________

How often? ______________________________

FUNCTIONAL HISTORY – Check off any that apply.

❑ Hearing Aid ❑ Dentures

❑ Walker / Cane ❑ Glasses / Contacts

PATIENT MEDICAL HISTORY (Page 3)

Today's Date ____________________________

Patient Name ____ Date of Birth ________________________

ALLERGIES - List all known allergies(drugs, food, animals, etc.).

[ ] **No known allergies**

____ ____
____ ____
____ ____
____ ____
____ ____

MEDICATIONS – List all medications that you take. Include prescription and non-prescription, as well as the dosage and frequency.

[ ] **I do not take any medications**

Medication Name	Dosage / Frequency