Patient Medical History

Name:_____ Date:_____ Date of Birth: _____

Do you have any allergies to medications or shots? □Yes □ No If yes, please list: _____

_____

PERSONAL MEDICAL HISTORY

Have you had any problems with the following, past or present?

Medical Problem	Yes/Date	Medical Problem	Yes/Date	Medical Problem	Yes/Date
Anemia		Emphysema/Chronic Bronchitis		Kidney Stones	
Anxiety		Fracture, which bone(s):_____		Liver Disease/Hepatitis	
Arthritis		Gall Stones		Pneumonia	
Asthma		Glaucoma		Problems During Pregnancy	
Bleeding Disorder		Gout		Pulmonary Embolism	
Blood Clot		Heart Attack		Restless Leg Syndrome	
Blood Transfusion		Heart Burn		Seasonal Allergies	
Breast Disease		Heart Murmur		Skin Disease, type:_____	
Cancer, type:_____		Hemorrhoids		Sleep Apnea	
Congestive Heart Failure		High Blood Pressure		STDs	
Dementia		High Cholesterol		Stomach Ulcer	
Depression		HIV		Stroke	
Diabetes, type 1		Hypertension		Thyroid Disease (High/Low)	
Diabetes, type 2		Insomnia		Tuberculosis	
Diverticulitis		Irregular Heartbeat		Ulcerative Colitis/Crohn's	
Eating Disorder		Kidney Disease/Infections			

Other: _____

Have you had any surgeries or major hospitalizations? □Yes □ No If yes, please list surgeries and approx. year:_____

_____

_____

Do you have any specialists or consultants (e.g., cardiologist, neurologist, etc)? □Yes □ No If yes, please list:_____

_____

Are you currently taking any medications? □Yes □ No If yes, please list:

Name	Dosage

Please list all over-the-counter medications, vitamins, and supplements:

Name	Dosage

SOCIAL HISTORY

Do you **or** have you ever used:

	Yes/No	How much/often	Dates of use
Cigarettes			
Other tobacco			
Alcohol			
Other drugs			
Caffeine			

What type of exercise do you get?

_____

_____

How often? _____

Do you have children? □Yes □ No If yes, please list ages:_____

continued on back

What is your occupation? If student, please list University and major(s)_____
Marital status: S M D W Other:_____ Spouse/Partner's name:_____
Sexually active: □Yes □ No □ Not currently Sex partner(s) have been: □ Male □ Female

HEALTH MAINTENANCE

When was your last: complete physical? _____ fasting blood work? _____ colonoscopy? _____
dexa (bone density) scan? _____ *(Females)* mammogram? _____ _ pap smear? _____
(Males): PSA/prostate? _____
Please check off any immunizations you have had. Add year, if known. Check this box if you don't know the information. □
Tetanus _____ With Pertussis (Tdap) _____ Varicella (Chicken Pox) shot *or* illness _____
Pneumovax (pneumonia) _____ Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____
MMR _____ Meningitis _____ Zostavax (shingles) _____ Gardasil (HPV) _____
Other_____

FEMALE HISTORY

Have you ever been pregnant? □Yes □ No If yes, how many times? _____ Number of living children:_____
Are you using any form(s) of contraception? □Yes □ No If yes, please list: _____
Are you still having periods? □Yes □ No If no, what was the approximate date of your last period? _____

FAMILY HISTORY

Please indicate with a check family members who have had any of the following conditions:

Medical condition	Mom	Dad	Sibling	Child
Alcoholism				
Anemia				
Arthritis				
Asthma				
Autoimmune disorder				
Bleeding problem				
Cancer, breast				
Cancer, colon				
Cancer, melanoma				
Cancer, ovary				
Cancer, prostate				
Cancer, other				
Depression				
Diabetes, type 1				
Diabetes, type 2				

Medical condition	Mom	Dad	Sibling	Child
Eczema				
Epilepsy (seizure disorder)				
Food allergies				
Heart attack (coronary heart disease)				
High cholesterol (Hyperlipidemia)				
High blood pressure (Hypertension)				
Kidney disease				
Obstructive sleep apnea				
Other genetic disease				
Restless leg syndrome				
Stroke				
Substance abuse				
Thyroid disorders				
Tuberculosis				

Other (please list):_____
_____