PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Reason for this Visit: _____

_____

_____

_____

_____

Medical History: (Check the items that apply to you, currently or in the past)

- ☐ None
- ☐ Anemia
- ☐ Bleeding Problem
- ☐ Blood Clots
- ☐ HIV / AIDS
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heartburn / Reflux
- ☐ Irregular Heart Beat
- ☐ Asthma
- ☐ Anxiety / Depression
- ☐ Chronic Lung (COPD)
- ☐ Pneumonia / Bronchitis
- ☐ Sleep Apnea
- ☐ Stomach Ulcers
- ☐ Liver Disease
- ☐ Pancreatitis
- ☐ Kidney Disease / Failure
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Cancer
- ☐ Leukemia
- ☐ Lymphoma

Other Medical History not listed above:

_____

_____

_____

_____

Have you ever experienced:

- ☐ Weight Loss – how much _____
- ☐ Fevers
- ☐ Chills
- ☐ Night Sweats
- ☐ Fatigue

PATIENT MEDICAL HISTORY FORM

Patient Name: _____

Please list all surgeries you have had with approximate date:

_____

_____

_____

_____

_____

_____

_____

Social History

Tobacco User:

- ☐ Never Smoked
- ☐ Quit Smoking When did you quit? _____ How many years did you smoke? _____ Yr(s)
- ☐ Currently smoke: What age did you start? _____ How many packs? _____ /day

Alcohol User: Present or Past

- ☐ Non-Drinker
- ☐ Drinker _____ Current _____ Past How many drinks per day? _____

Are you: _____ Employed _____ Unemployed _____ Retired _____ Disabled

(Former) Occupation: _____

Marital Status: ___ Married ___ Single Widowed ___ Divorced Domestic Partner

___ Lives alone ___ Lives with family

Children ___ Yes ___ No

Health Maintenance:

Sigmoidoscopy / Colonoscopy:	___ Yes	___ No	Date: _____
Mammogram:	___ Yes	___ No	Date: _____
Bone Density:	___ Yes	___ No	Date: _____
Pap Smear:	___ Yes	___ No	Date: _____
Influenza (Flu) Shot	___ Yes	___ No	Date: _____
Pneumococcal Shot:	___ Yes	___ No	Date: _____

PATIENT MEDICAL HISTORY FORM

Patient Name: _____

Family Medical History: Indicate any family members with cancer, blood disease or other disease

	Age at Diagnosis	Disease	If deceased, cause of death
Father			
Mother			
Siblings			
Siblings			
Other			

Drug Allergies (List all medication allergies):

_____

_____

_____

_____

_____

Pharmacy / address / phone#: _____

_____

List all medications (including non-prescription) that you are currently taking:

Medication	Dose	Frequency