

## PAST MEDICAL HISTORY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please fill in answer circle **completely** Correct = ●

**PAST MEDICAL HISTORY**– Please indicate if you have had any of the following illnesses by filling in the answer circle completely.

- |                                      |                                    |                                   |  |
|--------------------------------------|------------------------------------|-----------------------------------|--|
| <input type="radio"/> Anemia         | <input type="radio"/> Pnuemonia    | <input type="radio"/> Diabetes    | <input type="radio"/> High cholesterol         |
| <input type="radio"/> Seizures       | <input type="radio"/> Hepatitis C  | <input type="radio"/> Hepatitis B | <input type="radio"/> Environmental allergies  |
| <input type="radio"/> Kidney disease | <input type="radio"/> Cancer       | <input type="radio"/> Depression  | <input type="radio"/> Gall bladder disease     |
| <input type="radio"/> Stroke         | <input type="radio"/> Ulcers       | <input type="radio"/> Lupus       | <input type="radio"/> High blood pressure      |
| <input type="radio"/> Chest pain     | <input type="radio"/> Migraine     | <input type="radio"/> COPD        | <input type="radio"/> Atrial fibrillation      |
| <input type="radio"/> Tuberculosis   | <input type="radio"/> Heart attack | <input type="radio"/> AIDS/HIV    | <input type="radio"/> Congestive heart failure |
| <input type="radio"/> Asthma         |                                    |                                   |  |

**FAMILY HISTORY**– Please indicate any medical issues with these family members by filling in the answer circle completely.

- |          |                                |                                     |                              |                                    |
|----------|--------------------------------|-------------------------------------|------------------------------|------------------------------------|
| Mother   | <input type="radio"/> Diabetes | <input type="radio"/> Heart Disease | <input type="radio"/> Cancer | <input type="radio"/> Other: _____ |
| Father   | <input type="radio"/> Diabetes | <input type="radio"/> Heart Disease | <input type="radio"/> Cancer | <input type="radio"/> Other: _____ |
| Siblings | <input type="radio"/> Diabetes | <input type="radio"/> Heart Disease | <input type="radio"/> Cancer | <input type="radio"/> Other: _____ |

**SOCIAL HISTORY**–Please indicate any that apply by filling in the answer circle completely.

- |                  |                               |   |                                     |                                 |                                 |                               |
|------------------|-------------------------------|---|-------------------------------------|---------------------------------|---------------------------------|-------------------------------|
| Smoking tobacco  | <input type="radio"/> Yes     | <input type="radio"/> No (if No, skip to next question) |                                     |                                 |                                 |                               |
| Packs per day:   | <input type="radio"/> <1 PPD  | <input type="radio"/> 1 PPD                             | <input type="radio"/> 2 PPD         | <input type="radio"/> >3 PPD    |                                 |                               |
| Years active:    | <input type="radio"/> 1-5 yrs | <input type="radio"/> 6-10 yrs                          | <input type="radio"/> 11-15 yrs     | <input type="radio"/> 16-20 yrs | <input type="radio"/> 21-25 yrs | <input type="radio"/> >25 yrs |
| Chewing tobacco  | <input type="radio"/> Yes     | <input type="radio"/> No (if No, skip to next question) |                                     |                                 |                                 |                               |
| Years active:    | <input type="radio"/> 1-5 yrs | <input type="radio"/> 6-10 yrs                          | <input type="radio"/> 11-15 yrs     | <input type="radio"/> 16-20 yrs | <input type="radio"/> 21-25 yrs | <input type="radio"/> >25 yrs |
| Alcohol          | <input type="radio"/> No      | <input type="radio"/> Daily                             | <input type="radio"/> Socially only |                                 |                                 |                               |
| Illegal drug use | <input type="radio"/> Yes     | <input type="radio"/> No                                |                                     |                                 |                                 |                               |

**PEDIATRIC PATIENTS ONLY** – Please indicate if any of the following illnesses apply for the pediatric patient

- |   |                                      |   |                                   |
|---|--------------------------------------|---|-----------------------------------|
| <input type="radio"/> Jaundice                | <input type="radio"/> ADHD           | <input type="radio"/> Pneumonia               | <input type="radio"/> Prematurity |
| <input type="radio"/> Autism                  | <input type="radio"/> Lyme's disease | <input type="radio"/> Asthma                  | <input type="radio"/> Eczema      |
| <input type="radio"/> Chronic sinus disorders |                                      | <input type="radio"/> Environmental allergies |                                   |

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PAST MEDICAL HISTORY**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please tell us of any other medical conditions not listed previously, past surgeries and/or hospitalizations with date(s):

- 1. \_\_\_\_\_ Date: \_\_\_\_\_ 4. \_\_\_\_\_ Date: \_\_\_\_\_
- 2. \_\_\_\_\_ Date: \_\_\_\_\_ 5. \_\_\_\_\_ Date: \_\_\_\_\_
- 3. \_\_\_\_\_ Date: \_\_\_\_\_ 6. \_\_\_\_\_ Date: \_\_\_\_\_

Please indicate the last date which the following exams were performed:

**Female**

**Male**

Pap Smear	Yes	No	Date: _____	Prostate Exam	Yes	No	Date: _____
Mammography	Yes	No	Date: _____	Colonoscopy	Yes	No	Date: _____
Bone Density	Yes	No	Date: _____	PSA	Yes	No	Date: _____

**Medications:** Please list **all** current medications, dosages, and how you take them:

<b><u>Medication</u></b>	<b><u>Dosage</u></b>	<b><u>How many times a day?</u></b>
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**Allergies:** Please list drug and/or other allergies (in particular seafood, contrast dye, or iodine)

<b><u>Drug</u></b>	<b><u>Other</u></b>
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**Women Only:**

At what age was your first child born? \_\_\_\_\_

At what age did you start/stop your menstrual period? \_\_\_\_\_

Do you take hormones or birth control pills? \_\_\_\_\_

Do you practice monthly breast self exams? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_