

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:

<u>Medication</u>	<u>Dosage</u>	<u>How many times a day?</u>
--------------------------	----------------------	-------------------------------------

Allergies: Please list drug and/or other allergies (in particular seafood, contrast dye, or iodine)

<u>Drug</u>	<u>Other</u>
--------------------	---------------------

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: _____