

Medical History

Patient Name _____ Gender M F Date of Birth ____ / ____ / ____

Reason for Visit _____

Primary Care Physician _____

Allergies _____

Current Medications (including herbs, supplements, over the counter meds) _____

Medical History (List all past/current medical conditions) _____

Surgical History: ___ Appendectomy ___ Gall bladder removal ___ Hysterectomy ___ Other: _____

Please check positive social history below:

Smoker: No Yes, ____ pack/day for ____ years Quit

Alcohol: Never Rarely Occasional Quit

Recreational Drugs: No Yes, _____ Quit

Recently Traveled Abroad: No Yes, Location _____

Live Locally: Yes No, I live (where) _____

Please check positive family history below:

Mother: Deceased Diabetes Asthma Cancer Hypertension Coronary Heart Disease

Father: Deceased Diabetes Asthma Cancer Hypertension Coronary Heart Disease

Sibling: Deceased Diabetes Asthma Cancer Hypertension Coronary Heart Disease

Notes _____

Patient/Guardian Signature _____