

PATIENT MEDICAL HISTORY

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

VITALS Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_/\_\_\_\_\_ Temp: \_\_\_\_\_

FAMILY HISTORY

Table with 4 columns: Question, Cancer of breasts, female organs, colon, melanoma, Tuberculosis in the last 5 years, Diabetes, High blood pressure, Kidney trouble (other than kidney stones), Heart Disease, Anesthesia complication, Yes, No.

Exercise: Do you exercise at least 20 minutes, 3 times a week? Yes No

Alcoholic Beverages: \_\_\_\_\_ Never \_\_\_\_\_ Occassionally \_\_\_\_\_ Moderately \_\_\_\_\_ Daily

Smoking: Do you smoke? Yes No
If yes, how many packs per day?
If you quit, how long has it been?

Drug Use: Have you used, previously used, or had problems with any of the following:

\_\_\_\_\_ Marijuana \_\_\_\_\_ Heroin \_\_\_\_\_ Cocaine \_\_\_\_\_ Other Recreational Drug : \_\_\_\_\_

MEDICAL HISTORY Have you ever had any of the following:

Table with 6 columns: Condition, Yes, No, Condition, Yes, No. Rows include Asthma, Anemia, Tuberculosis, High Blood Pressure, Heart Disease, Diabetes, Depression, Thyroid disorder, Ulcer, Hepatitis, Hospitalization, Other, Drug Abuse.

Please explain "Yes" Answers: \_\_\_\_\_

IMMUNIZATIONS and OTHER

Have you had a tetanus shot in the last 10 years? Yes, Date \_\_\_\_\_ No

(Only age 50 and over) Have you had a pneumonia shot in the last 10 years? Yes, Date \_\_\_\_\_ No

Have you had any other immunization in the past? \_\_\_\_\_

Last Dental Exam: \_\_\_\_\_ Dentist Name: \_\_\_\_\_

Last Eye Exam: \_\_\_\_\_ Eye Dr Name: \_\_\_\_\_

SURGERIES (Please include Dates)

DRUG ALLERGIES:

MEDICATIONS: Please list all medications you are currently taking including dosage

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

