

PATIENT MEDICAL HISTORY

Name: _____ Age: _____ Occupation: _____

Chief Complaint: _____

VITALS Weight: _____ Height: _____ Blood Pressure: _____/_____ Temp: _____

FAMILY HISTORY

Table with 4 columns: Question, Condition, Yes, No. Rows include: Has any relative had: 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.

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

Alcoholic Beverages: _____ Never _____ Occasionally _____ 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 or breathing problems; Anemia (longer than 3 months); Tuberculosis; High Blood Pressure; Heart Disease or murmur; Diabetes; Depression; Thyroid disorder; Ulcer or stomach problems; Hepatitis, jaundice; Hospitalization for psychiatric reasons; 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: _____