MEDICAL HISTORY

NAME:_____ Age: _____ Date: _____

REASON FOR VISIT:_____

History of:	You	Relative(Who)
Heart Disease:	( )	_____
Diabetes:	( )	_____
Arthritis:	( )	_____
Hypertension:	( )	_____
Thyroid Disease:	( )	_____
Seizures:	( )	_____
Asthma:	( )	_____
Emphysema:	( )	_____
Chest Pain:	( )	_____
Swelling:	( )	_____
Bleeding:	( )	_____

History of:	You	Relative(Who)
Heart Attack:	( )	_____
Stroke:	( )	_____
Rheumatic Fever:	( )	_____
Kidney Disease:	( )	_____
Cancer:	( )	_____
Blood Clot:	( )	_____
Hepatitis:	( )	_____

Date last period:_____Last mammogram:____
Last PAP:_____Number of living children:____
Pregnancies:Full:___Preterm:____Abort/Miscarriage:___

Any other medical problems? _____
Do you or did you Smoke? _____How much? _____How long?_____When Did You Stop?_____
Do you or did you drink alcohol?_____What type?_____How often?_____When Did You Stop?_____
Do you use drugs? _____What type?_____How often?_____When Did You Stop?_____
Do you or have you ever taken steroids?_____

Family History: Age(current or at time of death)
Mother:_____Cause of death:_____
Father: _____Cause of death:_____
Brother:_____Cause of death:_____
Sister: _____Cause of death:_____
List additional siblings or relatives on back

Allergies To Medications	
Medication:	Reaction:
1.	
2.	
3.	

Current Medications		
Medication:	Dosage:	How Often:
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Past Surgeries	
Date:	Procedure:
1.	
2.	
3.	
4.	
5.	