

PATIENT HISTORY

PLEASE PRINT

Name: _____

Today's Date: _____

PERSONAL PAST MEDICAL HISTORY

Have you had any of the following illnesses?

	Yes	No		Yes	No		Yes	No
Allergies			Genital Warts			Malformation		
Abnormal Pap Smear			Hearing loss			Mental illness		
AIDS			Depression			Migraine headaches		
Anemia			Diabetes			Neurological disorders		
Angina pectoris			Emphysema			Nervous breakdown		
Arthritis			Epilepsy/seizures			Pneumonia		
Asthma			Gallbladder problems			Prostate problems		
Back problems			Glaucoma			Rheumatic fever		
Bleeding disorders			Gout			Sinus problems		
Blindness			Heart problems			Stomach ulcers		
Blood clots			Hepatitis			Stroke		
Blood transfusion			HIV positive			Thyroid problem		
Cancer			High Blood Pressure			Tuberculosis		
Cataracts			Urinary infections			Venereal disease/STD		
Cholesterol problem			Kidney problems			Other		
Colitis			Liver problems					

Have you had any of the following operations?

	Yes	No	Year		Yes	No	Year	IMMUNIZATIONS: Give dates, if available		
Amputation				Hysterectomy				Pneumonia		
Appendix				Prostate				Tetanus		
Back				Removal of ovaries				Hepatitis A or B		
Breast				Stomach				MEDICATION ALLERGIES:		
Cataract				Thyroid				() Check here if no allergies		
Heart Bypass				Tonsils				YES		YES
Gallbladder				Tubal ligation/sterilization				Penicillin		Codeine
Hernia				Vasectomy				Sulfa		Iodine
Hemorrhoid				Other				Aspirin		Other

CURRENT MEDICATION

Please bring a list of your current medications with you to your appointment, including, dosage and frequency.

The following questions are of a personal nature but may be important to your medical care. If you should feel uncomfortable answering any of these questions, please feel free to discuss this with your physician.

PERSONAL HABITS

- Do you currently smoke? ____ Yes ____ No ____ Cigarettes ____ Pipe ____ Cigars Number per day ____
 Have you ever smoked? ____ Yes ____ No Age started ____ Age stopped ____
 Have you ever regularly chewed or dipped tobacco? ____ Yes ____ No How long? ____ Amount per day ____ Current? ____ Yes ____ No
- Do you ever drink alcohol? ____ Yes ____ No
 If yes, please indicate frequency: ____ Rarely ____ Several times a month ____ Several times per week ____ Daily

FAMILY HISTORY

Relationship	Health Problems	If Deceased, cause and age
Father		
Mother		
Father's Parents		
Mother's Parents		

WOMEN ONLY – Menstrual History

Date of last Pap smear _____ Have you ever had a mammogram? ____ Yes ____ No Date of last mammogram _____

# of pregnancies	# born alive	# still births	# premature births	# C-Sections	# of miscarriages	# of abortions