Date: _____

Patient Medical History

Name:_____ Family Physician: _____ Office Phone: _____

Social History: Smoker: Y / N Are you a former smoker? Y / N When did you quit? _____ If you smoke how many packs per day?_____

How many years have you smoked? _____ Alcohol Usage: Y / N If so, do you drink: occasional social daily

Height: ___ ft. ____in Weight: _____ lbs. What is your age? _____ Date of Birth: _____

Allergies/Medications/Surgeries: Are you allergic to medications? Y / N If so, what medications and what reactions?_____

_____

List current medications to include vitamins and over the counter supplements. Please include dosages and daily dosage._____

_____

List any surgeries you have **EVER** had? List anytime you have been put to sleep for a procedure. _____

_____

Family History: Does any relative have/has had the following condition? If yes, what is their relation to you?

Breast cancer Y / N _____	Melanoma Y / N _____	High Blood Pressure Y / N _____
Stroke Y / N _____	Heart Disease Y / N _____	Diabetes Y / N _____
Kidney Disease Y / N _____	Depression Y / N _____	Clots in lungs/legs Y / N _____
Abnormal Bleeding Y / N _____	Cancer Y / N _____	

Personal Past Medical History: Do you have/had any of the follow medical conditions?

Heart Disease Y / N	Arthritis Y / N	Rheumatic Fever Y / N	Anemia Y / N	Tuberculosis Y / N
Diabetes Y / N	Cancer Y / N	Glaucoma Y / N	Asthma Y / N	AIDS/HIV Y / N
Stroke Y / N	Hepatitis Y / N	Stomach Ulcer Y / N	Kidney Disease Y /N	Thyroid Disease Y / N
Bleeding Tendency Y / N	Mitral Valve Prolapse Y / N	High Blood Pressure Y / N	Clotting in lungs/ legs Y / N	Staph Infection Y / N
Depression Y / N	Post Massive Weight Loss Y/ N	Ulcers Y / N		

Review of Symptoms: Do you have or have you ever had any of these symptoms? Please circle.

Allergies	Arthritis	Asthma	Chest pain	Depression
Heart attack	High blood pressure	Inflammation of veins	Murmur	Pacemaker
Phlebitis	Convulsions	Epilepsy/Seizure	Fainting	Fever/Chills
Significant Weight Gain/loss	Chronic Cough	Hearing loss	Morning cough	Sinus Disorder
Diabetes	Excessive thirst/hunger	Frequent Urination	Thyroid Disorder	Abdominal Pain
Diarrhea/Constipation	Gastro-intestinal Issues	Irregular heartbeat	Stomach Absorptive disorder	Ulcers
Bladder problems	Kidney Problems	Yeast infections	Anemia	Easy bleeding/bruising
Blood clots	Blood transfusion	Arthralgia	Artificial joint	Limited motion in joint
Muscle weakness	Paralysis	Numbness/tingling	Headache	Migraines
Bronchitis	Emphysema	Shortness of Breath	Tuberculosis	Wheezing
Dry Eyes	Vertigo	Skin Rash	Swollen feet/ankles	Swollen lymph nodes

Woman Only: Age periods began?_____ Do you do regular self breast exams? Y / N Last mammogram _____ N/A

Current/Past breast lump? Y / N Are you currently breast feeding? Y / N Do you plan to in the future? Y / N Have you in the past? Y / N

Please list the number of : _____ pregnancies _____ natural births _____ c-sections _____ miscarriages/abortions