Medical History *Name* ____________________

Date: / /

Past Medical History
(Please list all medical conditions for which you have been treated or are currently being treated)

____
____
____
____

Past Surgical History
(Please list all past surgeries that you have had)

____
____
____
____

Hospitalizations
(Please list all hospitalizations besides surgeries)

____
____
____
____

Medications
(Please list all medications you are currently taking. Include over the counter medicines, vitamins, dietary supplements, and herbal medications)

____
____
____
____

Allergies
(Please list allergies to medicine, food, and other substances. What reaction did you have?)

____
____
____
____

Immunizations
(Have you had the following immunizations?)

Hepatitis B	Yes	No	When?_____	Flu	Yes	No	When?_____
Pneumonia	Yes	No	When?_____	Tetanus	Yes	No	When?_____

Name ________________________

Preventive Care

When was your last
Pap smear?_____ Mammogram?_____ Prostate exam?_____
Cholesterol check?_____ Stool check for blood?_____

Family History

Relationship	Age	Alive	Deceased	Medical Problems / Cause of Death
Father	___	___	________	______________________________
Mother	___	___	________	______________________________
Siblings - Name				
______________	___	___	________	______________________________
______________	___	___	________	______________________________
______________	___	___	________	______________________________
______________	___	___	________	______________________________
Children - Name				
______________	___	___	________	______________________________
______________	___	___	________	______________________________
______________	___	___	________	______________________________
______________	___	___	________	______________________________
Father's side				
Grandfather	___	___	________	______________________________
Grandmother	___	___	________	______________________________
Mother's side				
Grandfather	___	___	________	______________________________
Grandmother	___	___	________	______________________________

Do you have a Family History of?

_____ Cancer (specify type): __ Colon __ Breast __ Lung __ Prostate __ Other
_____ Heart Disease
_____ Diabetes
_____ Kidney Disease
_____ Glaucoma/Vision Problems
_____ Arthritis
_____ Alcohol Problems
_____ Anemia
_____ Asthma
_____ Bleeding Problems
_____ Allergies
_____ Seizures/Convulsions/Epilepsy
_____ Ear/Hearing Problems
_____ Stroke
_____ Thyroid Problems
_____ TB
_____ Weight Problems
_____ Mental Illness
_____ Lead Poisoning
_____ Immune Problems
_____ HIV/AIDS
_____ High Cholesterol
_____ High Blood Pressure
_____ Skin Problems