



Medical Health History

Primary Reason For Today's Visit:

Current Prescriptions:

(Prescribed medications, dosage, vitamins, herbal supplements or protein drinks, special diet)

Allergies:

Surgeries or Hospitalizations:

Pharmacy of Choice

Name:	Phone #:	Fax #:
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Women Only (Exact Dates If Possible)

Age at first period:	Number of pregnancies:
Last Menstrual period:	Number of live birth(s):

Family Medical History

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Fibroid Disease | <input type="checkbox"/> Tuberculosis | | |

List any other diseases that run in your family and relationship to each family member listed:

Past and Current Medical History (Check All That Apply):

- | | |
|---|--|
| <input type="checkbox"/> Abnormal Mammogram | <input type="checkbox"/> Lung/Breathing Problems |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Mono |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Muscle Problems |
| <input type="checkbox"/> Breast Problems | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pelvic Pain |
| <input type="checkbox"/> Depression | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Female Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Genetic Disorders | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> STD's |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Hearing Trouble | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Vaginal Problems |
| <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Hormone Problems | |
| <input type="checkbox"/> Hot Flashes | |
| <input type="checkbox"/> Hypertension | |
| <input type="checkbox"/> Infertility | |
| <input type="checkbox"/> Irregular Periods | |

Last Checkup Dates	
Blood Test	
Chest X-Ray	
EKG	
Flu Injection	
Hepatitis Vaccine	
HIV Test	
Mammogram	
PAP	
Pneumonia Immunization	
PSA	
Rectal Exam	
Sigmoidoscopy	
TB Test	
Tetanus	

Social History	
Alcohol: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Caffeine: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chewing Tobacco: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cocaine: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diet Pills: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Exercise: <input type="checkbox"/> Yes <input type="checkbox"/> No	How Much? <input type="text"/>
Marijuana: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Smoking: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please sign and date: _____

If Patient is a minor Parent must sign

GUARDIAN