COMPANY NAME

PATIENT MEDICAL HISTORY FORM

Patient Name:_____ **Date of Birth:**_____

Patient Maiden Name or Former Name:_____

Date:_____ **Physician:**_____

How did you hear about us?_____

Are there any specialists you see?_____

PAST MEDICAL HISTORY: (Check conditions and illnesses for which you have been treated and include year of onset. List any other conditions which may not be included below.)

☐ No known medical problems	☐ Depression_____	☐ Meningitis_____
☐ Anemia_____	☐ Diabetes mellitus_____	☐ MI (Heart Attack)_____
☐ Anesthesia complications____	☐ Emphysema_____	☐ Nerve/Muscle disease_____
☐ Anxiety_____	☐ Environmental allergies_____	☐ Osteoporosis_____
☐ Arthritis_____	☐ GERD_____	☐ Seizures_____
☐ Asthma_____	☐ Glaucoma_____	☐ Sickle cell anemia_____
☐ Blood transfusion_____	☐ Heart murmur_____	☐ Stroke/TIA_____
☐ Cancer (list type below)_____	☐ HIV/AIDS_____	☐ Substance abuse_____
☐ Cataracts_____	☐ Hyperlipidemia_____	☐ Thyroid disease_____
☐ CHF_____	☐ Hypertension_____	☐ Tuberculosis/TB_____
☐ COPD_____	☐ Kidney disease_____	

Additional information/other history:_____

_____

PAST SURGICAL HISTORY: (Indicate year)

☐ No prior surgeries

☐ Appendectomy_____	☐ Eye surgery_____	☐ Small intestine surgery_____
☐ Brain surgery_____	☐ Fracture surgery_____	☐ Spine surgery_____
☐ CABG_____	☐ Hernia repair_____	☐ Tonsillectomy_____
☐ Cholecystectomy_____	☐ Joint replacement_____	☐ Valve replacement_____
☐ Colon surgery_____	☐ Prostate surgery_____	☐ Vasectomy_____
☐ Cosmetic surgery_____	☐ Hysterectomy_____	☐ Breast surgery_____
☐ C-section_____	☐ Tubal ligation_____	

☐ Other surgeries and/or hospitalizations:_____

_____

FAMILY HISTORY: (Include history of diabetes, heart disease, hypertension, colon, breast, ovarian cancer, other cancers, autoimmune diseases, and age at diagnosis if known)

Relative	**Alive/Deceased**	**Age**	**Health Problems**
Mother	_____	_____	_____
Father	_____	_____	_____
Sister	_____	_____	_____
Brother	_____	_____	_____
Child(ren)	_____	_____	_____

SOCIAL HISTORY:

Alcohol use: ☐ Yes ☐ No Number of drinks/frequency_____

Drug use: ☐ None ☐ Marijuana ☐Other_____

Caffeine use: ☐ None ☐ 1-3 servings/day ☐ 4-6/day ☐ >6/day Type_____

Tobacco use: ☐ Never ☐Currently smoke _____ pack(s) per day for _____years

☐ Previously smoked _____ pack(s) per day for _____ years

☐ Currently chew tobacco for _____years

☐ Previously chewed tobacco for _____ years. Quit_____

Marital status: ☐ Single ☐ Married ☐Partner ☐Widowed ☐Separated ☐Divorced

Children ☐ Yes ☐ No Ages_____

Exercise: ☐ None Days per week_____ Type_____

Occupation: _____

ALLERGIES:

Medication/food/environmental/drug allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

PREVENTIVE SCREENING AND VACCINATIONS:

Last influenza vaccination_____ Last pneumonia vaccination_____

Last shingles vaccination_____ Last tetanus vaccination_____

Last colonoscopy_____ Last PSA/prostate exam_____

Last Bone density test_____ Last pap smear_____

Last mammogram_____

OBSTETRIC/GYNECOLOGY HISTORY:

Number of pregnancies_____

Number of vaginal deliveries_____ Number of cesarean sections_____

Number of miscarriages_____ Number of abortions_____

Last menstrual period_____

Any pregnancy complications (i.e. gestational diabetes, pre-eclampsia)_____

History of sexually transmitted infection? ☐ Yes ☐ No Type/Year_____

MEDICATIONS, VITAMINS, AND SUPPLEMENTS:

Name	Strength/Number taken and frequency