PAST MEDICAL HISTORY

Date: **Name:** **Date of Birth:**

DRUG ALLERGIES
FAMILY HISTORY
FATHER: Living or Deceased Age
MOTHER: Living or Deceased Age
SIBLINGS: Living or Deceased Age
CHILDREN: Living or Deceased Age

FAMILY HISTORY				
	Father	Mother	Siblings	Children
Heart Disease				
High blood pressure				
Stroke				
Cancer				
Glaucoma				
Diabetes				
Epilepsy/Seizures				
Bleeding disorder				
Kidney disease				
Thyroid disease				
Mental illness				
Arthritis				

HOSPITALIZATION OR SURGERY

REASON	DATE	REASON	DATE

PAST MEDICAL HISTORY

___ Allergies/Hay fever
___ Anemia
___ Arthritis
___ Bowel irregularity
___ Bronchitis
___ Chest Pain
___ Chronic rashes
___ Depression
___ Dizziness/Fainting
___ Diabetes
___ Gallbladder disease
___ Gout
___ Headache/Migraines
___ Heart murmur
___ Heart palpitations
___ Hepatitis
___ High cholesterol
___ High triglycerides
___ Hypertension
___ Nervousness
___ Pneumonia
___ Prostate disease
___ Rheumatic fever
___ Seizure disorder
___ Sexual/Menstrual dysfunction
___ Shortness of Breath
___ Ulcer

Date of last Immunization

_____ Flu Vaccine
_____ Tetanus
_____ Pneumonia
_____ MMR
_____ PPD
_____ Other

HABITS

Smoke now? Yes No
Ever smoked? Yes No
Packs Daily? _____
How long? _____
Alcohol? Yes No
Type?_____
Amount?_____
Street drugs? Yes No
Contact with blood/body fluids at work? Yes No
Advanced Directive? Yes No
If yes, please provide copy

Coffee: cups daily? _____
Other caffeine? _____
Exercise routine? _____
Sleep patterns?_____
Fat intake? _____
Salt intake?_____
Diet: _____
Type? _____

MEN ONLY

Last PSA: Month Year

WOMEN ONLY

Menstruation: First at age _____
_____ days between periods Period last _____days
Flow is: light moderate heavy
Date of last period? _____
Pregnant? Yes No Planning? Yes No
Total # Pregnancies ____ Age of youngest child?____
Type of Birth Control?_____
Date of last Pap Smear?_____
Date of last Breast Exam _____
Date of last Mammogram

Please list any additional information about yourself that you feel will help the doctor in your evaluation: