PATIENT HISTORY FORM

To the patient or his representative: This form is intended to aid your attending physician in evaluating your past medical history. Please answer all appropriate questions as briefly as possible. This form is confidential and information given will become a part of the permanent medical record.

LIST ANY MEDICATIONS TAKEN DAILY: (INCLUDE DOSE AND FREQUENCY)

1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____
9.____
10.____

ALLERGIES:	YES	NO	NEVER TAKEN
Penicillin	_____	_____	_____________
Sulfa Drugs	_____	_____	_____________
Aspirin	_____	_____	_____________
Keflex	_____	_____	_____________
Codeine	_____	_____	_____________
Morphine	_____	_____	_____________
Tetanus	_____	_____	_____________

OTHER DRUG ALLERGIES (LIST):

____
____
____
____

FOOD ALLERGIES (LIST):

____
____
____
____

MEDICAL HISTORY:	YES	NO		YES	NO
Measles	___	___	Mastitis	___	___
Mumps	___	___	Migraine	___	___
Chicken Pox	___	___	Ear Infection*	___	___
Whooping Cough	___	___	Strep Throat*	___	___
Rheumatic Fever	___	___	Tonsillitis*	___	___
Pleurisy	___	___	Thyroid	___	___
Pneumonia	___	___	Bronchitis*	___	___
Gallstones	___	___	Emphysema	___	___
Kidney Stone	___	___	Kidney		
Diabetes	___	___	Infection*	___	___
Heart Attack	___	___	Prostate		
Epilepsy	___	___	Infection	___	___
Arthritis	___	___	Stomach Ulcer	___	___
High Blood Pressure	___	___	Varicose Veins	___	___
Tuberculosis	___	___	Stroke/Paralysis	___	___
Cancer	___	___	Hemorrhoids	___	___
Hypoglycemia			Anemia	___	___
(Love Blood Sugar)	___	___	Hepatitis	___	___
Blood Transfusions	___	___	*** reoccurring illness**		

Other Medical History:

____
____
____
____

PATIENT NAME:____
DOB:____

SURGERY:	YES	NO		YES	NO
Tonsilectomy	___	___	Hysterectomy	___	___
Adenoidectomy	___	___	Appendectomy	___	___
Thyroid Surgery	___	___	Hernia Repair	___	___
Gallbladder Removal	___	___	Hemorrhoid Surgery	___	___
Breast Biopsy or Removal	___	___	Removal of any Skin Tumor	___	___
Colonoscopy	___	___			

Other:____
____
____

TRAMA/INJURIES:	YES	NO
Cerebral (Brain) (Concussion)	___	___
Fractures (Broken Bones)	___	___

List:____
____
____

Dislocations(Joints):_____________________________________
____
____

Back Injury:____
____
____

OB-GYN **(FEMALES ONLY)**:

Total Pregnancies______________Total Live Births______________
Total Miscarriages______________
Onset of Menstrual Periods (Age) ______________
Age of Menopause______________
Any Child over 8 lbs at Birth YES___________NO__________
Last Pap Smear______________
Last Mammogram______________

VACCINATIONS: (Please provide date vaccination was administered):

Tetanus____________________ TB Skin Test__________________
Flu ____________________ Pneumonia __________________
Other ____

FAMILY HISTORY:

FATHER:

Living_____________ Age____________
Deceased__________ Age____________

If living, state of health
____
If deceased, cause of death
____

MOTHER:

Living_____________ Age____________
Deceased__________ Age____________

If living, state of health
____
If deceased, cause of death
____

PATIENT NAME:____
DOB:____

BROTHERS AND SISTERS:

Name	Living/Deceased	State of health/Cause of Death

CHILDREN:

Name	Living/Deceased	State of health/Cause of Death

Have any of your blood relatives (aunts, uncles, grandparents, children, parents, etc.) ever had the following?

	Yes	No	If yes, which relative?
Diabetes	___	___	________________________
Cancer (Type)	___	___	________________________
Tuberculosis	___	___	________________________
High Blood Pressure	___	___	________________________
Arthritis	___	___	________________________
Kidney Disease	___	___	________________________
Epilepsy (Fits)	___	___	________________________
Heart Disease	___	___	________________________
Heart Attack	___	___	________________________
Lung Disease	___	___	________________________
Strokes	___	___	________________________
Blood Disease	___	___	________________________
Thyroid Disease	___	___	________________________
Hepatitis	___	___	________________________
Other Infectious Diseases	___	___	________________________

SOCIAL HISTORY:

Occupation____
Alcohol: Yes__________ No__________
Quantity per week_________________________________
Tobacco: Yes__________ No__________
Packs of cigarettes per day__________________________
Have you ever smoked? Yes__________ No__________
Quit date_______________________________________

PERSONAL:	Yes	No
Married	___	___
Divorced	___	___
Widowed	___	___
Live Alone	___	___
Other	___	___

EMPLOYMENT STATUS:

	Yes	No
Employed	___	___
Unemployed	___	___
Retired	___	___

DOES YOUR WORK REQUIRE

	Yes	No
Lifting	___	___
Repetitive Action	___	___
Sitting Long Periods	___	___
Machinery Operation	___	___
Chemical Exposure	___	___

MILITARY SERVICE:

If yes, which branch?_______________________________________
Chemical Exposure? Yes_______ No_______

EDUCATION:

High School Completion___________________________________
College___________________________Years___________________
College Graduate: Yes_______ No_______
Vocational: Yes_______ No_______

Specialty doctors you are currently seeing (Cardiologist, Gynecologist, Gastroenterologist, etc…). Please list name and specialty:

____
____
____
____
____

WHAT PHARMACY DO YOU USE? (INCLUDE LOCATION):

____
____
____

__________________________________M.D.
Signature of Physician