Past Medical History Form

Patient Name_____ **Age** _____ **Date** _____

WHAT IS THE REASON YOU ARE SEEING THE DOCTOR TODAY? _____

MEDICATION ALLERGIES _____ **No** Known Allergies

Allergy _____ Reaction _____

Allergy _____ Reaction _____

CURRENT LIST OF MEDICATIONS (include dose, reason you take it, who prescribed it)

Medication Dose Quantity Frequency Use

_____

_____

_____

_____

CURRENT LIST OF OVER THE COUNTER MEDICATIONS (vitamins and food supplements)

_____

_____

Which of the following conditions are you currently being treated or have been treated for in the past?

(Please circle all that apply)

Heart disease/murmer/angina	Lung problems/cough	Ulcers/colitis	COPD
Animia/bleeding problems	Kidney/bladder	Eating disorder	Asthma
Swollen ankles/vein problems	High blood pressure	Sinus problems	Stroke
Sexually transmitted disease	Liver problem/hepatitis	Psychiatric care	Seizures
Eye disorder/glaucoma	Headaches/migraine	Ear problems	Tonsillitis
Neurological problems	Depression/anxiety	Hearing loss	Diabetes
Prostate problems	Rheumatic fever	Eating disorder	Arthritis
Thyroid problem	Seasonal allergies	Kidney stones	Hernia

Please describe any current or past medical treatment not listed above

_____

ADULT IMMUNIZATIONS Approximate date of last, or provide copy of immunization record

Tetanus (Td or TdaP) _____ Zoster (Shingles) _____

Pneumonia _____ Influenza (flu) _____

Have you ever been hospitalized overnight? ☐ Yes ☐ No If yes, give reason, when and where:

_____

_____

Females: History

How many times have you been pregnant? _____ Date of last Pap Smear _____

Have you had an abnormal Pap smear? ☐ Yes ☐ No If yes, what was treatment? _____

Date of last mammogram? _____ Have you ever had an abnormal mammogram? ☐ Yes ☐ No

Have you ever had a breast biopsy? ☐ Yes ☐ No

PHYSICIANS that you've seen previously: _____

Other SPECIALISTS you are currently seeing: _____

Please list your past surgeries. Include the year.

_____Angioplasty with stent _____Gallbladder removal _____Tonsillectomy _____LASIK

_____Appendectomy _____Gastric bypass _____Thyroidectomy _____Back surgery

_____Arthroscopy knee _____Hernia repair _____Pacemaker _____CABG(heart bypass)

_____other_____

FEMALE ONLY

_____Breast augmentation _____Breast reduction

_____Tubal ligation _____Hysterectomy

MALE ONLY

_____Prostate biopsy

_____Vasectomy

FAMILY HISTORY

	Living	Age (or age at death)	List medical problems
Mother	☐ Yes ☐ No	_____	_____
Father	☐ Yes ☐ No	_____	_____
Sisters	☐ Yes ☐ No	_____	_____
	☐ Yes ☐ No	_____	_____
	☐ Yes ☐ No	_____	_____
Brothers	☐ Yes ☐ No	_____	_____
	☐ Yes ☐ No	_____	_____

☐ Yes ☐ No _____ _____

How far did you get in school? _____

What is your profession? _____

Where did/do you work? _____

Who lives in your household? _____

Are you... Married Single Divorced Widowed? (Circle all that apply)

Do you have sex with men, women, or both? (Please circle)

Do you have any children? _____ If yes, list their name and ages.

_____

Hobbies? _____

Do you exercise? _____ What type? _____ How Often? _____

Do you smoke? _____ How much? _____ packs/day No. of years _____

Year you Quit_____

When was the last time you tried to quit? _____ how many times have you tried to quit? _____

Do you drink alcohol? _____ How much? _____ drinks/week No. of years _____

Year you QUIT _____ Previous or current problem with alcohol? _____ AA? _____

Previous Drug use (circle) Heroin marihuana cocaine methamphetamine chewing tobacco

Have you have had any of these symptoms recently? (Please circle all that apply)

Fever	Fatigue	Ear pain	Bloody nose
Sore throat	Tooth pain	Trouble sleeping	Thought of suicide
Chest pain	Palpitations	Heart racing	Cough
Shortness of breath	Wheezes	Acid reflux	Abdominal pain
Constipation	Diarrhea	Blood in stool	Hemorrhoids

Dark tarry stools	Nausea	Vomiting	Pain with urination
Blood in urine	Urinary frequency	Joint pain	Morning stiffness
Sore muscles	Rash	Unusual mole	Headache
Fainting	Memory loss	Weakness	Seizures
Tremor	Easy bruising	Heat/cold intolerance	Excessive thirst
Seasonal allergies	Anxiety	Depression	Panic