Medical History

PRINT LEGAL NAME: Date of Birth:

Please read and answer EVERY question! My previous ***physician*** was:

Thank you! I want to sign a release of records: Yes or No ? (circle one)

My PAST MEDICAL HISTORY		**IMMUNIZATIONS?**	YEAR	**My Preferred Pharmacy is:**	
Circle & write year it started	YEAR	FLU			
Asthma		TETANUS		If mail order fax # is:	
Cancer		HEPATITIS A		**All Past Surgeries**	LIST YEAR
Chronic Lung Disease		HEPATITIS B			
Diabetes		PNEUMONIA			
Heart Disease		Shingles			
High Blood Pressure		Gardasil			
High Cholesterol					
Mental Illness					
Osteoporosis		**List MEDICATIONS**			
Stroke		**ALL current medications & dose. Include:** mind altering substances			
Thyroid disease		laxatives, birth control, diet pills, vitamins, over-the-counter meds , etc			
Work related injuries?					
List others:					
ALLERGIES? (List all food or drugs)					
I'm ALLERGIC to:					
If none - please circle: ***None Known***					

My SOCIAL HISTORY Retired? Occupation (or previous):

My ethnic background is_____ Highest year completed in school: _____

(Circle one:) Single Married Divorced Widowed Single & living with significant other

Who else lives in my home? _____ . I have _____ (#) children. Their ages are: _____

My sexual orientation is: (please circle one) Gay Lesbian Bisexual Heterosexual

Activity level/exercise: _____ minutes per day?_____ Stress Level? High Medium Low (circle one)

Do you *smoke or chew tobacco?* **YES or NO** If so, how much and how often? _____ per day

At what age did you start smoking? _____ If quit, when? _____

Do you use any *illegal drugs including marijuana*? **YES or NO** **If so,** what? _____

How much? _____ How often? _____

Do you drink *caffeinated beverages*? **YES or NO** If so, how much & how ofte _____ per day

Do you drink *alcohol*? **YES or NO** If so, how much and how often? _____ per day, _____ per week

At what age did you start? _____ If quit, when? _____ *Hobbies/Activities:* _____

Do you have a ***Living Will*** or an ***Advanced Health Care Directive? Yes or N*** IF YES, PLEASE BRING IN NEXT TIME

My FAMILY'S MEDICAL HISTORY:

	AGE	List any Medical Problems	Living?	If no, cause of death?	At what age?
FATHER					
MOTHER					
BROTHER(S)					
SISTER (S)					
Other family member(s):					

Other pertinent information I want the doctor to know and/or **my main reason for seeing the doctor is**:

Patient's Signature: **Date**