PATIENT MEDICAL HISTORY

DATE_____

NAME_____

WHO REFERRED YOU TO OUR OFFICE ?_____

WHY WERE YOU REFERRED? _____

SOCIAL HISTORY

AGE_____ SEX_____ MARITAL STATUS_____

EDUCATION_____

OCCUPATION_____ HOURS WORKED (SCHEDULE)_____

NUMBER OF CHILDREN _____ NUMBER OF PERSONS LIVING IN YOUR HOME _____

CIGARETTED SMOKED PER DAY_____ ALCOHOL CONSUMED_____

FAMILY HISTORY

FATHERS AGE_____ IF DECEASED, AGE AT DEATH AND CAUSE_____

MOTHERS AGE_____ IF DECEASED, AGE AT DEATH AND CAUSE_____

TOTAL NUMBER OF BROTHERSOR SISTERS YOU HAVE OR HAVE HAD_____

HAVE ANY BLOOD RELATIVES OF YOURS HAD THE FOLLOWING? (YES OR NO):

_____HIGH BLOOD PRESSURE RELATIVE_____ AGE AT DX_____

_____DIABETES RELATIVE_____ AGE AT DX_____

_____HEART TROUBLE RELATIVE_____ AGE AT DX_____

_____CANCER RELATIVE_____ AGE AT DX_____

OTHER:_____ RELATIVE_____ AGE AT DX_____

OTHER:_____ RELATIVE_____ AGE AT DX_____

OTHER:_____ RELATIVE_____ AGE AT DX_____

(PLEASE SEE 2ND PAGE)

PERSONAL HISTORY

1. HAVE YOU EVER BEEN TREATED FOR HIGH BLOOD PRESSURE? _____

IF SO, AT WHAT AGE? _____

2. HAVE YOU EVER BEEN TREATED FOR HEART TROUBLE? _____

IF SO, AT WHAT AGE? _____

WHAT KIND OF HEART TROUBLE?
_____

3. HAVE YOU EVER BEEN TOLD YOU HAVE DIABETES? _____

IF SO, AT WHAT AGE? _____

FOR WOMEN: AT WHAT AGE DID YOUR MENSTRUAL PERIOD START? _____

IF THEY HAVE STOPPED, AT WHAT AGE DID THEY STOP? _____

WHAT OPERATIONS HAVE YOU HAD? (PLEASE LIST APPROXIMATE DATES)

_____

_____

_____

WHAT SERIOUS ILLNESSES OR INJURIES HAVE YOU HAD? (PLEASE LIST DATE)

_____

_____

_____

(PLEASE SEE 3RD PAGE)

MEDICATIONS: PLEASE LIST BELOW ALL MEDICATIONS THAT YOU ARE TAKING1) NOW 2) WITHIN THE PAST 12 MONTHS. BE SURE TO INCLUDE BOTH PRESCRIPTION AND OVER-THE-COUNTER DRUGS AND INDICATE THE DOSAGE AND NUMBER OF TIMES PER DAY:

NAME OF DRUG	DOSAGE	#OF TIMES PER DAY

NOW:

_____

_____

_____

_____

_____

_____

_____

_____

PAST 12 MONTHS

_____

_____

_____

_____

_____

(PLEASE SEE 4TH PAGE)

DRUG ALLERGIES: PLEASE LIST ALL MEDICATIONS TO WHICH YOU ARE ALLERGIC AND THE KIND OF SYMPTOMS THAT YOU EXPERIENCE.

MEDICATION NAME	**SYMPTOMS**

REVIEWED IN THE OFFICE ON _____ BY _____