



## Patient Medical History

**Patient Name:** \_\_\_\_\_ **Gender:**  Female  Male **Date of Birth:** \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**Medicine Allergies:** \_\_\_\_\_

\_\_\_\_\_

**Current Medications:** \_\_\_\_\_

\_\_\_\_\_

Past Medical History: \_\_\_\_\_

\_\_\_\_\_

**Reason for visit:** \_\_\_\_\_

\_\_\_\_\_

Please check positive family medical history below:

Mother:	<input type="checkbox"/> Deceased	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Coronary Artery Disease
Father:	<input type="checkbox"/> Deceased	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Coronary Artery Disease
Sibling:	<input type="checkbox"/> Deceased	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Coronary Artery Disease

Please check positive social history below:

Smoker:  No  Yes \_\_\_\_\_ pack/day for \_\_\_\_\_ years  Quit \_\_\_\_\_  
Alcohol:  Never  Rarely  Occasional  Heavy  Quit \_\_\_\_\_  
Recreational Drugs:  No  Yes \_\_\_\_\_  
Recently Traveled Abroad:  No  Yes, Location: \_\_\_\_\_  
Lives Locally  No  Yes, if No where: \_\_\_\_\_

Surgical History: \_\_ appendectomy \_\_ gall bladder removal \_\_ hysterectomy \_\_ other \_\_\_\_\_

\_\_\_\_\_

Additional Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

Physician Signature: \_\_\_\_\_