



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: _____