PAST MEDICAL HISTORY

Name _____ Date _____

DRUG ALLERGIES

_____

_____

FAMILY HISTORY

FATHER: Living or Deceased Age: _____

MOTHER: Living or Deceased Age: _____

SIBLINGS: Living or Deceased Age: _____

_____

_____

CHILDREN: Living or Deceased Age: _____

_____

FAMILY HISTORY

	FATHER	MOTHER	SIBLINGS	CHILDREN
Heart disease	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑
Stroke	❑	❑	❑	❑
Cancer	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑
Epilelpsy / Convulsions	❑	❑	❑	❑
Bleeding disorder	❑	❑	❑	❑
Kidney disease	❑	❑	❑	❑
Thyroid disease	❑	❑	❑	❑
Mental illness	❑	❑	❑	❑
Arthritis	❑	❑	❑	❑

HOSPITALIZATION OR SURGERY

REASON	DATE	REASON	DATE

PAST MEDICAL HISTORY

❑ Headache _____
❑ Shortness of breath _____
❑ Heart palpitations _____
❑ Heart murmur _____
❑ Chest pain _____
❑ Dizziness / Fainting _____
❑ Allergies / Hay Fever _____
❑ Asthma _____
❑ Bronchitis _____
❑ Pneumonia _____
❑ Ulcer _____
❑ Gallbladder disease _____
❑ Chronic rashes _____

❑ Prostate disease _____
❑ Bowel irregularity _____
❑ Sexual / Menstrual dysfunction _____
❑ Veneral disease _____
❑ Hepatitis _____
❑ Anemia _____
❑ Arthritis _____
❑ Nervousness _____
❑ Depression _____
❑ Gout _____
❑ High blood pressure _____
❑ High cholesterol _____
❑ High triglycerides _____

❑ Rheumatic fever _____
❑ Diabetes _____
❑ Scarlet fever _____
❑ Other _____
_____
_____
_____

Date of Immunizations:
❑ Diptheria _____
❑ Tetanus _____
_____
_____
_____

HABITS

Smoke now? _____ Coffee: Cups daily? _____
Never smoked? _____ Other caffeines? _____
Packs Daily? _____ Exercise routine? _____
How Long? _____ Sleep Patterns? _____
When stopped? _____ Fat intake? _____
Alcohol: Type/Amt. _____ Diet: Salt intake? _____
Contact with blood or body fluid at work? _____
Do you have a living will? ❑ Yes ❑ No

WOMEN ONLY

Menstruation: First at age _____.
_____ days between each period. Period lasts _____ days.
_____ Flow is light, moderate, heavy?
_____ Discomfort is light, moderate, heavy?
Date of last period? _____ Date of last Pap Smear? _____
Date of last Breast Exam? _____
Pregnant? ❑ Yes ❑ No ❑ Planning
Total # of Pregnancies _____ Full term delivery? _____
Number of living children _____ Ag of youngest? _____
Type of Birth Control? _____ Date of last Mammogram _____