



MEDICAL HISTORY FORM

NAME OF PATIENT _____ DOB _____

What prescription medicines do you take? _____

Are you allergic to any medications? _____

When was your last: mammogram _____ Colonoscopy _____ Blood Test _____

Immunizations _____

Have you had any surgeries and when? _____

Please list the medical conditions that you are being treated for now, or have been treated for in the past (ex. High blood pressure, serious infections, problems with blood, nervous system, heart, lungs, stomach, intestines, colon, liver, spleen, prostate, vision, hearing, ovaries, uterus, etc) Please list any other reasons for hospitalizations not listed above:

Do you smoke? _____ How many packs per day? _____ How old were you when you started? _____

Would you consider yourself a light, medium or a non-drinker? _____

Please list names and ages of family members in your household: _____

Family History: Please list member of family or deceased member that may have/had the following condition(s)

High Blood Pressure: _____

Diabetes: _____

Heart Attack: _____

Cancer of any type (including leukemia) _____

Does anything else “run” in your family? _____

WOMEN: How many times have you been pregnant? _____ How many children do you have? _____ What was the first day of your last menstrual period? _____