MEDICAL HISTORY

NAME: ______________________ DATE: ______________

D.O.B: ______________ AGE: ______________ PT ID#: ______________

Current medication(s) and/or supplements and dose/frequency:

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Drug Allergies: ______________________________

Surgeries:

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Have you ever had: (Please circle)

High blood pressure　Diabetes　High cholesterol

Arthritis　Hypothyroidism　Hyperthyroidism

Cancer: ______________ Heart problems: ______________

Lung problems: ______________ Kidney problems: ______________

Other: ______________________________

	Living?	**Health condition/cause and age of death**
Mother:	**Yes / No**	______________________
Father:	**Yes / No**	______________________

Family History: (If yes, please provide family relationship)

High blood pressure: ______________________

High cholesterol: ______________________

Diabetes: ______________________

Stroke: ______________________

Heart Attack: ______________________

Cancer: ______________________

Hereditary Conditions:

Have you ever had any of the following: (If yes, please provide a date)

- PFT (Pulmonary Function Test): ______________
- Sleep Study: ______________
- Colon cancer screen: ______________
- Endoscope: ______________
- Hearing Test: ______________
- Eye Exam: ______________

Have you ever had any of the following immunizations: (If yes, please provide a date)

- Tetanus (Every 10yrs): ______________
- Pneumonia (High risk and over 65): ______________
- Shingles (Over 60): ______________
- Flu (Every year): ______________

Last Pap Smear: ______________ Results: ______________

Last Mammogram: ______________ Results: ______________

Last Bone Density: ______________ Results: ______________

- Do you currently smoke tobacco: **Yes / No**

If yes; how many cigarettes per day: ______________

For how long: ______________

If no, have you ever smoked tobacco: **Yes / No**

How many cigarettes per day: ______________

For how long: ______________ Quit day: ______________

- Do you drink alcohol: **Yes / No**

If yes, how much do you drink: ______________