

PATIENT MEDICAL HISTORY

Please answer all of the questions as accurately possible. If you do not understand any questions please ask for assistance.

PATIENT NAME: _____

Date of Birth (mm/dd/yy): _____ Primary Care Doctor: _____

Smoking (type & amount per day): _____ Alcohol (type and amount per week): _____

If former smoker, date quit: _____ Height: _____ Weight: _____

Drug Allergies: _____

Past Surgeries (including cosmetic) or major illnesses and dates: none If yes, list here: _____

List any medications you are taking, including non-prescription drugs, vitamins, and herbals: _____

FAMILY MEDICAL HISTORY: Please place an "X" in the appropriate box if any blood relative has ever had the following:

Breast Cancer	<input type="checkbox"/> no <input type="checkbox"/> yes	High Blood Pressure	<input type="checkbox"/> no <input type="checkbox"/> yes	Kidney Disease	<input type="checkbox"/> no <input type="checkbox"/> yes
Melanoma	<input type="checkbox"/> no <input type="checkbox"/> yes	Heart Disease	<input type="checkbox"/> no <input type="checkbox"/> yes	Depression	<input type="checkbox"/> no <input type="checkbox"/> yes
Stroke	<input type="checkbox"/> no <input type="checkbox"/> yes	Diabetes	<input type="checkbox"/> no <input type="checkbox"/> yes	Tuberculosis	<input type="checkbox"/> no <input type="checkbox"/> yes

PERSONAL MEDICAL HISTORY: Please place an "X" in the appropriate box if you have ever had the following:

Heart Disease	<input type="checkbox"/> no <input type="checkbox"/> yes	Cancer	<input type="checkbox"/> no <input type="checkbox"/> yes	Stomach Ulcer	<input type="checkbox"/> no <input type="checkbox"/> yes
Arthritis	<input type="checkbox"/> no <input type="checkbox"/> yes	Glaucoma	<input type="checkbox"/> no <input type="checkbox"/> yes	Kidney Disease	<input type="checkbox"/> no <input type="checkbox"/> yes
Rheumatoid Fever	<input type="checkbox"/> no <input type="checkbox"/> yes	Asthma	<input type="checkbox"/> no <input type="checkbox"/> yes	Thyroid Disease	<input type="checkbox"/> no <input type="checkbox"/> yes
Anemia	<input type="checkbox"/> no <input type="checkbox"/> yes	AIDS or HIV+	<input type="checkbox"/> no <input type="checkbox"/> yes	Bleeding Tendency	<input type="checkbox"/> no <input type="checkbox"/> yes
Tuberculosis	<input type="checkbox"/> no <input type="checkbox"/> yes	Stroke	<input type="checkbox"/> no <input type="checkbox"/> yes	Mitral Valve Prolapse	<input type="checkbox"/> no <input type="checkbox"/> yes
Diabetes	<input type="checkbox"/> no <input type="checkbox"/> yes	Hepatitis	<input type="checkbox"/> no <input type="checkbox"/> yes	High Blood Pressure	<input type="checkbox"/> no <input type="checkbox"/> yes

REVIEW OF SYSTEMS: Please place an "X" in the appropriate box if you have now or had within the past year:

Weight Change	<input type="checkbox"/> no <input type="checkbox"/> yes	Swollen Feet/Ankles	<input type="checkbox"/> no <input type="checkbox"/> yes	Seizures	<input type="checkbox"/> no <input type="checkbox"/> yes
Dry eyes	<input type="checkbox"/> no <input type="checkbox"/> yes	Skin Rash	<input type="checkbox"/> no <input type="checkbox"/> yes	Joint/Muscle Pain	<input type="checkbox"/> no <input type="checkbox"/> yes
Chronic cough	<input type="checkbox"/> no <input type="checkbox"/> yes	Chronic diarrhea	<input type="checkbox"/> no <input type="checkbox"/> yes	Swollen Lymph Nodes	<input type="checkbox"/> no <input type="checkbox"/> yes
Chest pain	<input type="checkbox"/> no <input type="checkbox"/> yes	Jaundice	<input type="checkbox"/> no <input type="checkbox"/> yes	Easy Bleeding	<input type="checkbox"/> no <input type="checkbox"/> yes
Rapid heart rate	<input type="checkbox"/> no <input type="checkbox"/> yes	Depression	<input type="checkbox"/> no <input type="checkbox"/> yes	Easy Bruising	<input type="checkbox"/> no <input type="checkbox"/> yes

WOMEN ONLY:

Age period began _____

Number of pregnancies _____

Date of last mammogram: _____

Did you breast feed? no yes

Do you do regular breast self-examinations? no yes

Breast lump or discharge? no yes

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature of patient (or parent if patient is under 18 years of age)

Date