Patient Medical History

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History**

Anxiety Depression Kidney Stones

Asthma Diabetes Liver Disease

ADD GERD/Reflux Prostate Disease

ADHD Heart Attack Stroke

Bipolar Heart Disease Thyroid Disease (hypo/hyper)

Cancer, type?\_\_\_\_\_\_\_\_\_\_ Hypertension Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cholesterol IBS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COPD Kidney Disease

**Past Surgical History**

Appendix Hernia Neurosurgery

Back Hysterectomy (partial/total)

Bladder Kidney

Breast Laparoscopy Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

C-Section Prostate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cataract Tonsils

Gallbladder Thyroid

**Social History**

(YES/NO) Do you smoke? (YES/NO) Employed (Full Time/Part Time) (YES/NO) Married

If yes, how much? \_\_\_\_\_\_ If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(YES/NO) Single

(YES/NO) Do you drink alcohol? (YES/NO) Retired

If yes, how much? \_\_\_\_\_ (YES/NO) Divorced

(YES/NO) Student

(YES/NO) Recreational Drug Use If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (YES/NO) Widowed

(YES/NO) Unemployed (YES/NO) Disabled Number of Children:\_\_\_\_\_\_\_\_\_

Who do you live with:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preventative Maintenance: Family History: Medications:**

(please list date if possible) Mother: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ Pap Smear Living: \_\_\_\_\_ Deceased: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ Mammogram Medical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ Bone Density \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ EKG \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ Prostate Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ Colonoscopy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ Eye Exam Father:

\_\_\_\_\_\_\_\_ X-Ray (type?) Living: \_\_\_\_\_ Deceased: \_\_\_\_\_ **Allergies:**

\_\_\_\_\_\_\_\_ PSA Medical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ Vaccines \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ Self Breast Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_