Stephanie A. Stein, M.D., PLLC
Patient Medical History

PATIENT NAME: _____ **DATE:** _____

Past Medical History: (check all that apply)

☐ Anemia	☐ Gallbladder Disease	☐ Lung Problems	☐	☐
☐ Asthma	☐ Headaches	☐Seizures	☐	☐
☐ Back Problems	☐ Heart Disease	☐Skin Problems	☐	☐
☐ Blood Transfusion	☐ Head Injury	☐ Substance Abuse	☐	☐
☐ Bowel Problems	☐ Hepatitis	☐ Thyroid Disease	☐	☐
☐ Breast Disease	☐ High Blood Pressure	☐ Ulcers	☐	☐
☐ Cancer	☐ High Cholesterol	☐ Other: (please list)	☐	☐
☐ Depression	☐ Kidney Disease	☐	☐	☐
☐ Diabetes	☐ Liver Disease	☐	☐	☐

Surgical History:

Type of Surgery:	**Location of Procedure:**	**Place and Approximate Date:**
1.		
2.		
3.		
4.		
5.		

Family History: ***Please specify any relative with the following conditions***

☐ Patient Adopted	**Mother**	**Father**	**Daughter**	**Son**	**Sister**	**Brother**	**Runs in Family**
Living	☐	☐	☐	☐	☐	☐	
Deceased	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	☐
Breast Disease	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐
Emotional Problems	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure (Hypertension)	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐

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Social History:

Marital Status:	Employment:	Tobacco History:	Alcohol History:	Illegal Drugs:
☐ Single	☐ Currently Employed	☐ Current Every Day Smoker	☐ Never drinks alcohol	☐ Never used illegal drugs
☐ Married	☐ Retired	☐ Current Some Day Smoker	☐ Currently drinks alcohol	☐ Currently uses illegal drugs
☐ Divorced	☐ Student	☐ Former Smoker	☐ Quit	☐ Quite less than 3 years ago
☐ Separated		☐ Never Smoker		☐ In the past only
☐ Widowed				

Medication History:

Please list all of the medications you currently take, including prescription strength and directions. (Example: Lipitor, 10 mg, 1 time daily)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Allergies:

Please list your allergies, or check box if none.

Food:	Drug:	Environmental:
☐ No Food Allergies	☐ No Drug Allergies	☐ No other allergies

Immunizations:

Please provide us with a copy of the patient's Immunizations if done elsewhere.

For Women Only:

Menstrual History		Birth Control
Age at first menstruation: _____	Last Pap Smear: _____	☐ None
Age at Menopause: _____	Results: _____	☐ Type used: _____
Last Menstrual Period: _____		

Additional Questions:

Last Colonoscopy Date:		Do you wear seatbelt?	☐ Yes ☐ No
Last Dexa/Bone Scan Date:		Do you have a living will?	☐ Yes ☐ No
Last Mammogram Date: Last Pap Smear Date:		Do you have a smoke detector and is it regularly checked?	☐ Yes ☐ No

Patient Name & Signature: _____ **Date:** _____