Medical History

Full Legal Name: _____ **Date of Birth:**_____

Current Medications/Supplements/Vitamins

	Name of Medication	Strength	Frequency Taken
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Do you have any drug allergies? __ Yes ___ No If yes, what medications? _____

Current Medical Illnesses			Date of Onset	Doctor's Notes
1. Heart Disease	Yes	No	_____	_____
2. Stroke	Yes	No	_____	_____
3. High Blood Pressure	Yes	No	_____	_____
4. High Cholesterol	Yes	No	_____	_____
5. Diabetes	Yes	No	_____	_____
6. Cancer of _____	Yes	No	_____	_____
7. Asthma or COPD	Yes	No	_____	_____
8. Low Thyroid	Yes	No	_____	_____
9. Depression	Yes	No	_____	_____
10. HIV positive	Yes	No	_____	_____
11. Other:_____			_____	_____

Previous Surgeries	Date of Surgery
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

If None ☑ box ☐

Do you smoke? Yes No If yes, how many packs per day? _____
Do you drink? Yes No If yes, how many drinks per day? _____
Do you use drugs? Yes No If yes, what types? _____

Occupation: _____ Marital status: single married divorced widowed
If you are married, what is your spouse's name? _____

Family History Are any of the following diseases present in any family members? **CHECK ☑ any that apply**

	List the types of Cancer	Diabetes	Heart Disease	+ Age of onset	High Blood Pressure	Stroke	**If None Apply ☑ box**
Father	_____	_____	_____	_____	_____	____	☐
Mother	_____	_____	_____	_____	_____	____	☐
Sisters	_____	_____	_____	_____	_____	____	☐
Brothers	_____	_____	_____	_____	_____	____	☐
Children	_____	_____	_____	_____	_____	____	☐

If your parents are deceased, what was the cause of death? Father: _____ Mother: _____

Gynecologic History (for women only)

Have you gone through menopause ___Yes ___No If yes, what age? _____
Date of onset of last menstrual period? ____/_____/____ (give month/date/year)
Are your menstrual cycles regular? ___Yes ___No
Date of last PAP Smear ___/___/___ Was the result normal? ___Yes ___No
History of abnormal PAP results in the past? ___Yes ___No
Number of pregnancies _____ Number of live births: _____ Miscarriages: _____

Date of last Influenza Vaccine:_____ **Approximate month and year (ex- 6/2014)**

Date of Pneumonia Vaccine:_____ **Approximate month and year (ex- 6/2014)**