Patient Medical History

Date:_____

Name: Date of birth: / /

Have to ever been or are currently diagnosed with any of the following?	Yes	No
Diabetes Type I		
Diabetes Type II		
Hypoglycemia		
Thyroid Disease		
Coronary artery disease		
High Blood pressure		
Elevated cholesterol or triglycerides		
Asthma		
COPD		
Allergic Rhinitis		
Kidney stones		
Gall stones or gallbladder disease		
Stomach disorders (heartburn, reflux, gastric ulcers)		
Intestinal disorders (Chronis constipation, diarrhea, Krohn's, enteritis, diverticulitis)		
Migraines or severe or chronic headaches		
Fainting spells, dizziness, or vertigo		
Anemia		
Arthritis		
Osteoporosis		
Glaucoma		
Gout		
Sleep apnea		
Seizure disorder or history of convulsions		
Depression		
Severe anxiety, panic attacks, or bipolar disorders?		

Are you aware of any other diagnosis you may have that has not been listed above? **Please explain:**

_____

_____

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Preventative exams: Normal?	Yes	No	Date:
Last Pap smear			
Mammogram			
Dexa scan (Bone density test)			
EKG			
Colonoscopy			
Eye exam			
Prostate exam			
PSA blood work			
Surgical history:	**Yes**	**No**	**Date:**
Tonsillectomy			
Widsom-teeth extraction			
Lasik			
Cataracts (Right eye)			
Cataracts (Left eye)			
Cholecystectomy (gallbladder removal)			
Appendectomy			
Vasectomy			
Hysterectomy			
Breast augmentation			
Breast reduction			
Lumpectomy			
Rhinoplasty			

Please list any other surgeries you may have had in the past with the dates:

If female:	Yes	No
Date of last menstrual period? : / /		
Number of heavy days?		
Are your periods regular? (About every 28-30 days)		
How many pregnancies? : _____ Full term? : _____ Premature births? :_____		
Miscarriages? : _____ Abortions? :_____		
Have you gone through menopause?		
If yes, at what age?		

Social History:	Yes	No
Marital status (Circle one) : Married Single Divorced Widowed		
Do you currently smoke?		
If yes, How many packs a day?		
Are you a former smoker?		
If yes, how many years did you smoke?		
When did you quit?		
Do you keep a gun at home?		
Do you consume any alcohol?		
If yes, how many drinks to you have per week, per month?		
If yes, circle all that apply: Beer Wine Liquor		
Do you drink any caffeinated beverages?		
If yes, how many cups a day?		
Do you exercise routinely?		
If yes, how often? (3 time per week, month?) And how long is the workout?		

Current pharmacy information:

Allergies	Reactions

Current medication list (include all over the counter meds and vitamins)		
Medication name	Strength or dosage	How often a day is it taken?