

# MEDICAL HISTORY

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_  
LAST FIRST M.I.

OCCUPATION: \_\_\_\_\_

REASON FOR VISIT TODAY: \_\_\_\_\_

ALLERGIES (Include medications, foods, xray dyes) or ☐ NONE KNOWN

| Name of allergen | Type of reaction | Approximate date |
|------------------|------------------|------------------|
| 1                |                  |                  |
| 2                |                  |                  |
| 3                |                  |                  |

CURRENT MEDICATIONS (Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or ☐ NONE

| Name of medication | Dose (mg) | How often taken | Reason for taking medication | Physician prescribing |
|--------------------|-----------|-----------------|------------------------------|-----------------------|
| 1                  |           |                 |                              |                       |
| 2                  |           |                 |                              |                       |
| 3                  |           |                 |                              |                       |

PHARMACY (list pharmacy most frequently used for prescriptions)

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

PREVIOUS HOSPITALIZATIONS (Include all non surgical hospitalizations. Attach extra sheet if necessary) or ☐ NONE

| Reasons for hospital stay | Date (approximate) | Hospital or city if known |
|---------------------------|--------------------|---------------------------|
| 1                         |                    |                           |
| 2                         |                    |                           |
| 3                         |                    |                           |

SURGERIES (Include all surgery in your lifetime. Attach extra sheet if necessary) or ☐ NONE

| Type of surgery | Date (approximate) | Hospital or city if known |
|-----------------|--------------------|---------------------------|
| 1               |                    |                           |
| 2               |                    |                           |
| 3               |                    |                           |

OB/GYN HISTORY: No. of Pregnancies: \_\_\_\_\_ No. of Deliveries: \_\_\_\_\_ Last Menstrual cycle: \_\_\_\_\_

## TOBACCO HISTORY

Are you an active cigarette smoker? ☐ Yes ☐ No

Have you ever been a cigarette smoker? ☐ Yes ☐ No

If yes, I smoked an average of \_\_\_\_\_ packs/day for \_\_\_\_\_ years. I quit in \_\_\_\_\_ (year)

Do you use other tobacco products? ☐ Yes ☐ No

If yes, please specify \_\_\_\_\_

## ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism? ☐ Yes ☐ No

Do you currently drink alcohol regularly? ☐ Yes, currently ☐ Never/rarely

If yes, approximately how many drinks per week (beer, wine, or liquor) \_\_\_\_\_

Have you ever used intravenous drugs? ☐ Yes ☐ No

## FAMILY HISTORY

| Is there a history in your family of: | Yes | No | Affected relative(s) |
|---------------------------------------|-----|----|----------------------|
| Heart attack                          |     |    |                      |
| Diabetes                              |     |    |                      |
| Prostate cancer                       |     |    |                      |
| Kidney cancer                         |     |    |                      |
| Kidney stones                         |     |    |                      |
| Other significant disease             |     |    |                      |

