Patient Name: _____ MEDICAL HISTORY Patient Date Of Birth: _____

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes
(If yes, please list names of medicine and type of reaction):

_____ _____ _____

Please list and supply the dates of:
Operations: _____ _____ _____
_____ _____ _____
Hospitalizations other than for surgery:
_____ _____ _____
_____ _____ _____
_____ _____ _____

Immunization history- have you had:
Pneumovax Immunization? ☐ No ☐ Yes When? _____ Hepatitis B? ☐ No ☐ Yes When? _____
Tetanus Immunization ? ☐ No ☐ Yes When? _____ Flu? ☐ No ☐ Yes When? _____
When was your last Pap? _____ Mammogram? _____
Colonoscopy?_____
Stool check for blood? _____ Cholesterol Check? _____ Prostate exam? _____
Do you drink alcohol? _____How many drinks/week? _____
Do you smoke cigarettes? _____How many packs per/day? _____
Do you wear a seat belt? _____Living Will? _____

History:
Have you or any members of your family (including parents, grandparents, and siblings) ever had the following?

Illness	You	Which family members?
Cancer	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart disease	_____	_____
Diabetes	_____	_____
Drug or Alcohol Use	_____	_____
Strokes	_____	_____
Mental disease (anxiety, depression, etc)	_____	_____
Lung Disease	_____	_____
Kidney Disease	_____	_____
Bleeding diseases	_____	_____
Other: _____	_____	_____

Medications (Prescriptions, Over-the-counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

This information is for use by your physician as part of your confidential medical record. Please continue on back.