PATIENT AND FAMILY HISTORY

Name _____ Date _____

Birthdate _____

What is your chief symptom or medical problem at this time? _____

_____

CURRENT MEDICATIONS

Drug Name MG Times/Day

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES OR INTOLERANCE TO MEDICINES

_____

_____

_____

PERSONAL SURGICAL HISTORY (Include hospitalizations other than childbirth.)

_____

_____

_____

PAST MEDICAL HISTORY (i.e. heart disease, blood pressure, diabetes, cancer)

_____

_____

_____

PERSONAL & SOCIAL

Have you ever been a cigarette smoker? ☐ Y ☐ N

How many cigarettes do you smoke daily? _____

How many alcohol drinks do you have daily? _____

Have you lived outside the U.S.? ☐ Y ☐ N

Are you: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ?

Number of children _____ Ages _____

What forms of exercise do you get? _____

FAMILY HEALTH

	PRESENT AGE	AGE AT DEATH	CAUSE OF DEATH	ASTHMA	HEART DISEASE	BLOOD PRESSURE	STROKE	DIABETES	MIGRAINES
FATHER									
MOTHER									
BROTHERS									
SISTERS									