PATIENT HISTORY FORM

Today's Date: _____
Name: _____
DOB: _____Marital Status: _____

Last Medical Exam: _____
Last Doctor: _____
Females only:
Last mammogram: _____Pap Smear: _____

Allergies: _____
_____
_____
Medications: (list all medications including non prescription)
_____
_____
_____
_____
_____
Previous Medical Illness, Surgeries, or Hospitalizations:
_____
_____
_____
_____
_____
_____
Do you have any medical problems?
_____
_____
_____
_____
_____
_____
OB/GYN History: Pregnancies: _____ Deliveries: _____
Current Tobacco Use? # of packs per day: _____Yrs? _____
Alcohol Use? _____oz per week or number of glasses
Drug Use? _____

Family History: Check the box next to the condition that your family member has.

___alcoholism	___anemia	___asthma	___arthritis
___bleed easily	___breast cancer	___colon polyps	___colon cancer
___diabetes	___glaucoma	___gout	___heart disease
___high bp	___iron disease	___kidney disease	
___mental illness	___migraine	___osteoporosis	___prostate cancer
___seizures	___thyroid disease	___tuberculosis	

Immunizations: When was your last booster?
Tetanus: _____
Flu Vaccine: _____
Pneumonia: _____

Advanced Directives: Please discuss with your spouse or family and your physician.
Living Will? Yes ___No___ Organ donor? Yes___No___
Durable Power of Attorney for Health Care? No___Yes___ Who? _____