Patient Medical History

Patient name: ____ Date: ______________

Patient History			Family History		
Asthma	Y	N	Asthma	Y	N
Cancer	Y	N	Cancer	Y	N
COPD / chronic bronchitis	Y	N	COPD / chronic bronchitis	Y	N
Diabetes	Y	N	Diabetes	Y	N
Digestive problems	Y	N	Digestive problems	Y	N
Ear / hearing problems	Y	N	Ear / Hearing Problems	Y	N
Epilepsy / seizures	Y	N	Epilepsy / Seizures	Y	N
Eye / vision problems	Y	N	Eye / vision problems	Y	N
Heart disease	Y	N	Heart disease	Y	N
High blood pressure	Y	N	High blood pressure	Y	N
Kidney disease	Y	N	Kidney disease	Y	N
Memory problems	Y	N	Memory problems	Y	N
Musculoskeletal problems	Y	N	Musculoskeletal problems	Y	N
Stroke	Y	N	Stroke	Y	N
Surgeries	Y	N	Surgeries	Y	N
Thyroid problems	Y	N	Thyroid problems	Y	N
Weight changes	Y	N	Bleeding disorder	Y	N
Hospitalization	Y	N	Osteoporosis	Y	N

Please explain any / all issues marked "yes" (Y) above (use back if you need more room)

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Medications: ____

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Allergies: ____

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Social History			Date of last			
Smoker	Y	N	Blood work	_______	Eye exam	_______
Drink alcoholic beverages	Y	N	Colonoscopy	_______	Dental exam	_______
Ever used illegal drugs	Y	N	Flu shot	_______	Hep B vac	_______
Live alone	Y	N	Mammogram	_______	Pap smear	_______
Major life stressors	Y	N	Pneumonia vac	_______	Prostate exam	_______
			Tetanus vac	_______	TB test	_______