Past Medical, Social, Surgical, Family History

Instructions: Complete the following information by placing a checkmark in the appropriate boxes or by PRINTING the requested information.

Today's date _____/_____/_____ Patient name: _____

DOB_____/_____/_____ Sex: M___ F___

PAST MEDICAL HISTORY

Have you ever been hospitalized? Y___ N___ Describe:

Have you ever had serious injuries or broken bones? Y___ N___ Describe:

Have you ever received a blood transfusion? Y___ N___ Year:

Have you had the following preventative care measures?

Colonoscopy Y___ N___ Year_____ Results_____Where_____

Females: Pap Y___ N___ Year_____ Results_____ Where_____

Mammogram Y___ N___ Year_____ Results_____ Where_____

Males: PSA Y___ N___ Year_____ Results_____ Where_____

Have you ever had any of the following No Yes If yes, Describe

Abnormal chest xray N Y Describe _____

Anesthesia complications N Y _____

Anxiety, depression, mental illness N Y _____

Abnormal bleeding/anemia/other N Y _____

Diabetes N Y _____

Colon or rectum polyps/tumors N Y _____

High blood pressure N Y _____

High cholesterol or triglycerides N Y _____

Stroke or TIA N Y _____

Have you ever had any of the following No Yes Describe (including surgery)

Sexually transmitted disease N. Y. _____

Treatment for alcohol or drug use N. Y. _____

Tuberculosis or positive skin test N. Y. _____

Cosmetic or plastic surgery N Y _____

Cataract or glaucoma N Y _____

Ear, nose, sinus, or tonsil problems N Y ___ _____

Thyroid or parathyroid problems N Y _____

Abnormal heart rhythm N. Y _____

Heart problems/heart attack N Y _____

Peripheral vascular disease N Y _____

Blood clots N Y _____

Lung problems (asthma COPD etc) N Y. _____

Esophagus or stomach (ulcer) N Y _____

Bowel problems N. Y _____

Liver or gallbladder (including hepatitis) N. Y _____

Hernia N Y _____

Kidneys or bladder N. Y _____

Bones, joints, muscles N. Y_____

Back neck or spine N. Y. _____

Skin or breast problems N. Y _____

Females: uterus, tubes, ovary problems N. Y _____

Males: prostate, penis, tests, vasectomy N. Y _____

Other: describe N. Y _____

SOCIAL HISTORY

Education: how many years of school have you completed?_____

Occupation:_____Retired?_____

Are you disabled?_____

Married?_____

Do you drink alcohol? Y___ N___ How many per day?_____

Do you smoke? Y___ N___ How many packs per day?_____

Year started_____ Year Quit_____

Recreational drugs? Y___ N___ Which ones?_____

Have you ever had treatment for drug or alcohol addiction? Y___ N___

Do you exercise? Y___ N___ How often?_____ What do you do to exercise?_____

_____

Do you follow any special diet? Y___ N___ If so, what kind of diet?_____

FAMILY HISTORY

Are you adopted? If so, complete only about blood relatives.

Mother:Alive___Age____Deceased___Year____Cause_____

Father:Alive___Age____Deceased___Year____Cause_____

Brothers:#____#Living____#Deceased____Cause_____

Sisters:#____#Living____#Deceased____Cause_____

Children:_____Ages_____

Any history of Cancer, Heart disease, Diabetes, Stroke/TIA, high blood pressure in family? Y___ N___

If so, who?_____

MEDICATIONS

Name Dose How often taken

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies to medicines or foods Reaction

_____

_____

_____

_____

Have you had an allergic reaction to:

Contrast dye or iodine? Y___ N___ Bees or wasp stingsY___ N___

Latex or Rubber Y___ N___Adhesive tape Y___ N___