MEDICAL HISTORY FORM

Name: _____ DOB: _____

General State of Health: Excellent Good Fair Poor

Number of Children: _____

Do you smoke? YES NO _____ Packs per day

_____ smoking years

Do you drink alcoholic beverages? YES NO

How much? _____

Are you on any type of diet? _____

Are you happy with your weight? _____

Do you exercise? YES NO How much? _____

When was your last physical exam? _____

Reason for today's visit? _____

_____

Allergies: _____

Do you have any hormone issues? YES NO

If yes, please explain: _____

_____

_____

Previous Hospitalizations and/or surgery: _____

_____

Current Medications (including over the counter): __

_____

Female History

Age of onset of periods? _____

Are periods regular? YES NO

# of Pregnancies: _____ # of Miscarriages: _____

Are you Pregnant? YES NO Form of Birth Control:___

Age of "Change of Life": _____

Do you do self-breast exams? YES NO

Family	Age	Illness	Cause of Death
Mother			
Father			
Siblings			

FAMILY HISTORY of: (please circle)

Family – Sugar Diabetes Psychiatric Illness

Overweight Alcoholism

High Cholesterol Bleeding Disorder

Heart Attack Anemia

Stroke Glaucoma

Tuberculosis Lung Cancer

Lung Problems Breast Cancer

Asthma Colon Cancer

Stomach Cancer Other Cancer

Personal–Past MEDICAL HISTORY:(have you had any)

Depression Suicide Attempt

Heart Problems Venereal Disease

Sugar Diabetes Arthritis

Overweight Thyroid Problem

Stroke Gout

Chronic Bronchitis Anemia

Emphysema High Cholesterol

Asthma Bleeding Problems

Tuberculosis Glaucoma

Hepatitis Ulcer

Urinary Stone Urinary Infection

Seizures Migraines

Decreased Vision Decreased Hearing

Other Disorders of: Breast, Stomach Bowel, Blood Vessels, Gallbladder, Pancreas, Kidneys, Prostate