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Past Medical History

Name: _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ Gender: ☐Male ☐Female

Race: ☐Caucasian ☐Hispanic ☐African American ☐Asian ☐Indian ☐Pacific Islander ☐Other
Occupation: _____
Number of Children: _____ Ages: _____

The highest level of education I attend is: None: ☐ Elementary: ☐ Partial High School: ☐
High School Graduate:☐ Partial College:☐ College Graduate:☐ Post Graduate:☐ Other: _____

Are you currently smoking? No: ☐ Yes: ☐ How many years: _____
I smoke _____ packs of cigarettes per day, _____ pipes full per day, _____ of cigars per day

I presently drink alcohol on a regular basis? No: ☐ Yes: ☐
How many per week? _____ Glasses of wine, _____ Bottles of beer, _____ other drinks

Have you ever used alcohol on a regular basis in the past? No: ☐ Yes: ☐
I stopped drinking alcohol on a regular basis on or about: _____/_____/_____
I drank per week approximately: _____ glasses of wine, _____ bottles of beer, _____ other drinks

Do you consume caffeine daily: No: ☐ Yes: ☐
If yes, I consume __cups of tea, ___cups of coffee, ___chocolate drinks or candy, ___oz. caffeinated soft drinks per day

Do you exercise regularly? No: ☐ Yes: ☐
How many times per week do you exercise: _____ How many minutes per exercise session? _____

MEDICATIONS:
Are you allergic to any medication(s): No: ☐ Yes: ☐

Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____

Are you taking any medicine (Prescription and/or over the counter): No: ☐ Yes:☐

Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____

Are you taking any controlled drugs? No: ☐ Yes: ☐

Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____
Name of drug: _____ Describe the effect: _____

PLEASE TURN OVER AND COMPLETE MEDICAL HISTORY

Past Medical History

Past Illness:

Have you ever had allergies: (Hay Fever, Asthma, Other) No: ☐ Yes: ☐ **If yes:**

Allergy Type: _____ Date started: ___/___/___ Date of most recent episode ___/___/___ Still Active? No: ☐ Yes: ☐
Allergy Type: _____ Date started: ___/___/___ Date of most recent episode ___/___/___ Still Active? No: ☐ Yes: ☐
Allergy Type: _____ Date started: ___/___/___ Date of most recent episode ___/___/___ Still Active? No: ☐ Yes: ☐
Allergy Type: _____ Date started: ___/___/___ Date of most recent episode ___/___/___ Still Active? No: ☐ Yes: ☐

Any Illness or Conditions: No: ☐ Yes: ☐

Describe: _____ Date: _____/_____/_____
Describe: _____ Date: _____/_____/_____
Describe: _____ Date: _____/_____/_____
Describe: _____ Date: _____/_____/_____

Have you had any surgery? No: ☐ Yes: ☐

Type: _____ Date: _____/_____/_____
Type: _____ Date: _____/_____/_____
Type: _____ Date: _____/_____/_____
Type: _____ Date: _____/_____/_____

Have you been Hospitalized? No: ☐ Yes: ☐

Reason: _____ Date: _____/_____/_____
Reason: _____ Date: _____/_____/_____
Reason: _____ Date: _____/_____/_____
Reason: _____ Date: _____/_____/_____

Have you had any Injuries? No: ☐ Yes: ☐

Describe: _____ Date: _____/_____/_____
Describe: _____ Date: _____/_____/_____
Describe: _____ Date: _____/_____/_____
Describe: _____ Date: _____/_____/_____

Did any immediate family members have any disease? No: ☐ Yes: ☐

Relative: _____ Date: _____/_____/_____
Relative: _____ Date: _____/_____/_____
Relative: _____ Date: _____/_____/_____
Relative: _____ Date: _____/_____/_____

For Women Only:

Are you post menopausal? No: ☐ Yes: ☐	Date of last breast exam: _____/_____/_____
Date of last menstrual period: _____/_____/_____	Date of Mammogram: _____/_____/_____
Are you pregnant? No: ☐ Yes: ☐	Date of last Pap test: _____/_____/_____
If yes, expected date of delivery: _____/_____/_____	
Are you planning a pregnancy? No: ☐ Yes: ☐ If yes, When: _____/_____/_____	
Form of contraception:	