

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.

<input type="checkbox"/> alcoholism	<input type="checkbox"/> anemia	<input type="checkbox"/> asthma	<input type="checkbox"/> arthritis
<input type="checkbox"/> bleed easily	<input type="checkbox"/> breast cancer	<input type="checkbox"/> colon polyps	<input type="checkbox"/> colon cancer
<input type="checkbox"/> diabetes	<input type="checkbox"/> glaucoma	<input type="checkbox"/> gout	<input type="checkbox"/> heart disease
<input type="checkbox"/> high bp	<input type="checkbox"/> iron disease	<input type="checkbox"/> kidney disease	
<input type="checkbox"/> mental illness	<input type="checkbox"/> migraine	<input type="checkbox"/> osteoporosis	<input type="checkbox"/> prostate cancer
<input type="checkbox"/> seizures	<input type="checkbox"/> thyroid disease	<input type="checkbox"/> 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? _____