

PATIENT MEDICAL HISTORY

Date: _____

Last Name: _____ First Name: _____ MI: _____

Height _____ Weight _____

Immunizations: _____, _____, _____, _____, _____

If you are ≥ 65 years of age, have you ever received a Pneumococcal Vaccine? Yes No If yes, please enter the date here: Month _____ Year _____

If you are ≥ 50 years of age, have you received an influenza immunization during this flu season? Yes No If yes, please enter the date here: Month _____ Year _____

Please list all your Medical Problems:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Please list all Drug Allergies:

1. _____ Reaction _____
2. _____ Reaction _____
3. _____ Reaction _____
4. _____ Reaction _____

Other Allergies:

1. _____
2. _____
3. _____

Please list all your MEDICATIONS. Prescription and Non-Prescription and Any Supplements

1. _____ Dose: _____ How Often: _____
2. _____ Dose: _____ How Often: _____
3. _____ Dose: _____ How Often: _____
4. _____ Dose: _____ How Often: _____
5. _____ Dose: _____ How Often: _____
6. _____ Dose: _____ How Often: _____
7. _____ Dose: _____ How Often: _____

**Please use the back of this page if you need to add to your list.

PATIENT MEDICAL HISTORY (pg 2)

Date: _____

Last Name: _____ First Name: _____ MI: _____

SOCIAL HISTORY

Number of Children: _____

Smoking Status: Non-Smoker _____

Ex-Smoker _____ How many years smoked? _____ Packs Per day _____ When Quit: _____

Smoker _____ How many years smoked? _____ Packs Per day _____

Alcohol: Abstains Rare Social Daily Drinks per day _____

Please list all past operations:

1. _____ When: _____

2. _____ When: _____

3. _____ When: _____

4. _____ When: _____

List any screening tests that have been done: (i.e. Mammogram, Colonoscopy, Flex sig, MRI etc.)

1. _____ When: _____ Where: _____

2. _____ When: _____ Where: _____

3. _____ When: _____ Where: _____

4. _____ When: _____ Where: _____

FAMILY HISTORY

RELATIVE	DIAGNOSIS	CAUSE OF DEATH	COMMENT	AGE
FATHER	_____	_____	_____	_____
MOTHER	_____	_____	_____	_____
SISTER	_____	_____	_____	_____
BROTHER	_____	_____	_____	_____
OTHER	_____	_____	_____	_____
OTHER	_____	_____	_____	_____

PLEASE ADD ANY ADDITIONAL INFORMATION THAT MAY HELP US WITH YOUR CARE:
