Medical and Health History Form

Patient Name:_____ Age:_____ Birthdate:_____

Please answer <u>all questions</u> as accurately as possible. If you do not understand the question, please ask for assistance.

Reason for today's visit: _____ Primary care doctor: _____

Do you smoke nicotine? *Yes No* Amount per day_____How soon upon waking _____

Are you ready to quit? *Yes No* Do you drink alcohol? *Yes No* Do you use Marijuana? *Yes No*

Height _____Weight_____ Have you had a flu shot? *Yes No* When? _____

Do you have an Advanced Directive? *Yes No* Do you have a Latex Allergy? *Yes No*

<u>Drug Allergies</u>:_____

List previous surgeries (Cosmetic and medical) and dates:

_____

<u>Family History:</u>

Have any **<u>immediate family member(s)</u>** ever had the following: (**please circle F-father; M-mother; S-sister; B-brother**)

□Breast Cancer F M S B	□ Melanoma F M S B	Father:	Alive	Deceased
□High Blood Pressure F M S B	□ Heart Disease F M S B	Mother:	Alive	Deceased
□Kidney Disease F M S B	□ Depression F M S B	Brother:	Alive	Deceased
□Stroke F M S B	□Diabetes F M S B	Sister:	Alive	Deceased

<u>Past Medical History:</u>

Have **<u>you</u>** ever had the following:

□Heart Disease	□Arthritis	□Rheumatic Fever	□**NONE**
□Cancer	□Glaucoma	□Asthma	
□Stomach Ulcer	□Kidney Disease	□Thyroid Disease	
□Anemia	□Tuberculosis	□Diabetes	
□AIDS or HIV	□Stroke	□Hepatitis	
□Bleeding Tendency	□Mitral Valve Prolapse	□High Blood Pressure	

□**Other**:_____

<u>Review of Systems:</u>

Do you have or have you had within the past year:

□Weight Change	□Dry Eyes	□Chronic Cough	□**NONE**
□Swollen feet/ankles	□Skin Rash	□Chronic Diarrhea	
□Seizures	□Joint/Muscle Pain	□Swollen Lymph Nodes	
□Chest Pain	□Depression	□Easy Bleeding	
□Jaundice	□Easy Bruising	□Rapid Heartbeat	

<u>Women only:</u>

Date of last mammogram _____ Are you currently breastfeeding? _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. THIS FORM MUST BE COMPLETED BEFORE SEEING THE DOCTOR.

Patient Signature/Guardian

Date