Patient Name:_____ Date of Birth:_____ Today's Date: _____

Personal Medical History

Please list names and phone numbers of other providers you see or have seen in the past:

Name of provider:	Specialty: (e.g. Cardiologist)	Phone Number:

Surgery or Hospitalization:	Month/Year:	Name of Surgeon:

Vaccine:	Yes/No		Date:
Influenza	YES	NO	
Pneumonia	YES	NO	
Whooping Cough (TDaP)	YES	NO	
Hepatitis A/B	YES	NO	
HPV (Gardasil)	YES	NO	
Shingles	YES	NO	
COVID Vaccine	YES	NO	

Other Past History:			
Do you smoke?	YES	NO	Packs per day ___ Years _____
Have you quit smoking?	YES	NO	When:
Do you drink alcohol?	YES	NO	____ # Drinks Per Day/Week
Do you or have you ever used recreational drugs?	YES	NO	Which type: How often:
Have you quit using the above mentioned drugs?	YES	NO	When:
Do you Exercise?	YES	NO	How often:
Do you have pets?	YES	NO	What type:

Patient Name:_____ Date of Birth:_____ Today's Date: _____

Family History	**Please Circle:**	**Age (now or at death):**	**Medical Condition or Cause of Death:**
Mother	Alive / Deceased		
Father	Alive / Deceased		
Maternal Grandmother	Alive / Deceased		
Maternal Grandfather	Alive / Deceased		
Paternal Grandmother	Alive / Deceased		
Paternal Grandfather	Alive / Deceased		
Sibling	Alive / Deceased		
Sibling	Alive / Deceased		
Child	Alive / Deceased		
Child	Alive / Deceased		

Prior Diagnostic History:			**Date:**	**Ordering Physician:**
Pap Smear	YES	NO		
Mammogram	YES	NO		
Colonoscopy	YES	NO		
EKG	YES	NO		
Cardiac Stress Test	YES	NO		
ECHO	YES	NO		
Chest X-Ray	YES	NO		
Pulmonary Test Function	YES	NO		
CT Scan (which body part)	YES	NO		
Bone Density	YES	NO		
Eye Exam	YES	NO		
Hearing Test	YES	NO		
Memory Test	YES	NO		
Lab Work	YES	NO		

For Female Patients Only:			**Description/Additional Comments:**
Have you ever been pregnant?	YES	NO	Number of pregnancies: Number of Live births: Number of Miscarriages: Number of Abortions:
Are you planning pregnancy?	YES	NO	
Age at onset of menstruation			_____
Amount of menstrual flow			Light / Moderate / Heavy / Clots
Are your periods regular?	YES	NO	
Age at onset of menopause			_____

Patient Name:_____ Date of Birth:_____ Today's Date: _____

Have you every used birth control pills, patches, or implants?	YES	NO	If yes, how long?
Have you every used hormone replacement therapy?	YES	NO	If yes, how long?
Did you ever have an abnormal PAP?	YES	NO	If yes, when?

Do you have any of the following?:					
ADD/ADHD	YES	NO	High Cholesterol	YES	NO
Anxiety Disorder	YES	NO	Hyperthyroidism	YES	NO
Arthritis	YES	NO	Hypotension	YES	NO
Asthma	YES	NO	Hypothyroidism	YES	NO
Auto Immune Disease	YES	NO	Inflammatory Bowel Disase	YES	NO
Bipolar Disorder	YES	NO	Irregular Heart Rhythm	YES	NO
Bleeding Disorder	YES	NO	Liver Dysfunction	YES	NO
Cataracts	YES	NO	Lung Disorders	YES	NO
Cerebrovascular Accident (Stroke)	YES	NO	Kidney failure or Dysfunction	YES	NO
Chemotherapy (if yes, state when)	YES	NO	Migraines	YES	NO
Clotting Disorder	YES	NO	Muscular Dystrophy	YES	NO
Congenital Heart Defects	YES	NO	Myocardial Infarction (Heart Attack)	YES	NO
Coronary Artery Disease	YES	NO	Obstructive Sleep Apnea	YES	NO
COPD	YES	NO	Organ Transplant (if yes, please describe)	YES	NO
Dementia	YES	NO	Osteoporosis	YES	NO
Depression	YES	NO	Pancreatitis	YES	NO
Diabetes	YES	NO	Polycystic Ovarian Syndrome	YES	NO
Dialysis	YES	NO	Pulmonary Artery Hypertension	YES	NO
End Stage Renal Disease	YES	NO	Radiation Therapy (If yes, explain)	YES	NO
Fibromyalgia	YES	NO	Recurrent Infections	YES	NO
Gallstones	YES	NO	Restless Leg Syndrome	YES	NO
Gastritis or Gastric Ulcers	YES	NO	Scoliosis	YES	NO
GERD (reflux problems)	YES	NO	Seizure Disorder	YES	NO
Glaucoma	YES	NO	Skin Disorder (Psoriasis, Acne)	YES	NO
Heart or Valve Defects	YES	NO	Urinary Retention or Urgency	YES	NO
Hemorrhoids	YES	NO	**Other:**		
HIV or AIDS	YES	NO			
High Blood Pressure	YES	NO			

Patient Medication List

PLEASE PRINT

Patient Name: _____ Date of Birth: _____

Are you allergic to any medications? □ Yes □ No

If so, please list the medications and reactions: _____

_____

Please list all medications you are taking (Prescription, Over the Counter, Vitamins, and Supplements):

Name:	Dose:	How Often:

Do you take any type of blood thinners? □ Yes □ No Do you take Aspirin? □ Yes □ No

Pharmacy:

Local Pharmacy (please list cross streets if known): _____

Mail Order Pharmacy: _____