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PERSONAL MEDICAL HISTORY

Date: _____
Name: _____ DOB: _____
Primary Doctor: _____Date of last physical:_____
Current medical problem: _____
_____
Chronic medical condition: _____
_____
Medications (List all prescription and non-prescription medications that you are taking including vitamins, herbals, and supplements: _____
_____
Allergies (medicine, food, contrast, or other): _____
_____
Previous Surgeries: _____
When was your last…
Period: _____ Mammogram: _____ Pap Smear: _____
Dexa Scan: _____Colonoscopy: _____ Prostate Exam: _____

Please check any of he following that apply to you:

___High Blood Pressure
___High Cholesterol
___Cardiovascular Disease/Rheumatic fever
___Diabetes
___Osteoporosis
___Benign Prostatic Hyperplasia
___Seizures
___Tobacco use
___Alcohol use
___Caffeine use
___Asthma/COPD/TB
___Erectile Dysfunction
___Insomnia
___Malnutrition/Muscle loss
___Other_____
___Depression
___Migraines/Frequent Headaches
___Cancer _____
___Eating Disorders
___Stroke
___Phlebitis/Cots/Varicose vein
___Vision Problems
___Liver Disease/Hepatitis
___Mononucleosis
___Kidney/Bladder problem
___Thyroid Disease
___Anemia/Sickle cell
___Abnormal Mammogram
Breast Lumps/Discarge

Family History

Are you adopted? ( ) YES ( ) NO
Indicate who of your blood relatives (parents, grandparents, brothers or sister(s)) have or had any of the following problems:

_____Heart attack/Coronary artery disease
_____Diabetes
_____Stroke
_____Phlebitis/Clots in veins
_____Sickle Cell/ Tay Sacks/ Thalassermia
_____High Blood Pressure
_____Breast Cancer
_____Cancer
_____Births defects/Genetic
_____Other_____
_____

If you have any questions or additional comments, use this space:_____
_____

PLEASE READ AND SIGN: "I Acknowledge that the above information is correct and complete."

Patient Signature: _____Date: _____