Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Patient Medical History

Please answer every question.

STAFF: Handwritten responses must be entered **MANUALLY**.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Age:_____ **Home Phone #:**_____ **Cell Phone #:**_____

Referring Provider:_____ **Family Doctor:**_____

Reason for Visit Today:_____

Symptoms and Duration:_____

SOCIAL HISTORY

TOBACCO USE

Are you exposed to passive (second hand) **smoke?** yes ○ no ○

What is your smoking status? current (every day) ○ previous ○ current (some days) ○ never ○

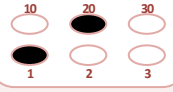
At what age did you begin smoking?

If you quit smoking, at what age did you quit?

How many cigarettes do you currently smoke (or did you previously smoke) **per day?**

10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

EXAMPLE
If you started smoking at the age of 21, you would fill in the ovals like this:



ALCOHOL USE

Do you consume alcohol? no ○ in the past ○ rarely ○ monthly ○ weekly ○ daily ○

If so, which type(s): wine ○ beer ○ liquor ○

CAFFEINE USE

Do you consume caffeine? no ○ occasionally ○ regularly ○

If so, average number of drinks per day: 1-2 ○ 3-4 ○ 5+ ○

If so, which type(s): coffee ○ tea ○ soft drinks ○

ILLICIT DRUG USE

Do you take drugs recreationally? no ○ in the past ○ yes ○

PAST MEDICAL HISTORY

Please mark all conditions that you have had:

- ○ Anemia
- ○ Arthritis
- ○ Asthma
- ○ Bladder / Urinary Problems
- ○ Bleeding / Blood Disorder
- ○ Bowel Disease
- ○ Breast Lump
- ○ Cancer (please specify type):
  _____
- ○ Chest Pain
- ○ Congestive Heart Failure (CHF)
- ○ COPD
- ○ Diabetes
- ○ GERD (Reflux)
- ○ Heart Attack
- ○ Heart Disease
- ○ Hepatitis
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ HIV / AIDS
- ○ Kidney Disease
- ○ Kidney Stones
- ○ Leg Pain or Swelling
- ○ Lung Disease
- ○ Mood Disorder
- ○ Neurologic Disease
- ○ Nipple Discharge
- ○ Prostate Issues
- ○ Rectal Bleeding
- ○ Seasonal Allergies
- ○ Shortness of Breath
- ○ Stomach Disease
- ○ Stroke
- ○ Overactive Thyroid
- ○ Underactive Thyroid
- ○ Ulcers

Other Condition(s):
_____

○ **NO SIGNIFICANT MEDICAL HISTORY**

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FAMILY HISTORY

Do any of your family members have a history of the following?

- MOTHER'S Family History Unknown
- FATHER'S Family History Unknown
- Adopted

	MOTHER'S SIDE						FATHER'S SIDE						
	Mother	Father	Grandmother	Grandfather	Aunt	Uncle	Grandmother	Grandfather	Aunt	Uncle	Brother	Sister	Child
Bladder Stones	○	○	○	○	○	○	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○	○	○	○	○	○	○
Kidney Stones	○	○	○	○	○	○	○	○	○	○	○	○	○
Prostate Cancer		○		○		○		○		○	○		○

Have any of your family members had Colorectal Cancer? If yes, please indicate their age when the condition developed:

	YES	NO	20's	30's	40's	50's	60's	70's	80's	90's
Mother	○	○	○	○	○	○	○	○	○	○
Father	○	○	○	○	○	○	○	○	○	○
Brother	○	○	○	○	○	○	○	○	○	○
Sister	○	○	○	○	○	○	○	○	○	○
Aunt	○	○	○	○	○	○	○	○	○	○
Uncle	○	○	○	○	○	○	○	○	○	○
Grandmother (Mother's Side)	○	○	○	○	○	○	○	○	○	○
Grandfather (Mother's Side)	○	○	○	○	○	○	○	○	○	○
Grandmother (Father's Side)	○	○	○	○	○	○	○	○	○	○
Grandfather (Father's Side)	○	○	○	○	○	○	○	○	○	○

Have any of your family members had Breast Cancer? If yes, please indicate their age when the condition developed:

	YES	NO	20's	30's	40's	50's	60's	70's	80's	90's
Mother	○	○	○	○	○	○	○	○	○	○
Father	○	○	○	○	○	○	○	○	○	○
Brother	○	○	○	○	○	○	○	○	○	○
Sister	○	○	○	○	○	○	○	○	○	○
Aunt	○	○	○	○	○	○	○	○	○	○
Uncle	○	○	○	○	○	○	○	○	○	○
Grandmother (Mother's Side)	○	○	○	○	○	○	○	○	○	○
Grandfather (Mother's Side)	○	○	○	○	○	○	○	○	○	○
Grandmother (Father's Side)	○	○	○	○	○	○	○	○	○	○
Grandfather (Father's Side)	○	○	○	○	○	○	○	○	○	○

Have any of your family members had Renal (Kidney) Cancer? If yes, please indicate their age when the condition developed:

	YES	NO	20's	30's	40's	50's	60's	70's	80's	90's
Mother	○	○	○	○	○	○	○	○	○	○
Father	○	○	○	○	○	○	○	○	○	○
Brother	○	○	○	○	○	○	○	○	○	○
Sister	○	○	○	○	○	○	○	○	○	○
Aunt	○	○	○	○	○	○	○	○	○	○
Uncle	○	○	○	○	○	○	○	○	○	○
Grandmother (Mother's Side)	○	○	○	○	○	○	○	○	○	○
Grandfather (Mother's Side)	○	○	○	○	○	○	○	○	○	○
Grandmother (Father's Side)	○	○	○	○	○	○	○	○	○	○
Grandfather (Father's Side)	○	○	○	○	○	○	○	○	○	○

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SURGICAL HISTORY

Please mark all surgeries that you have had. Please include the year of each surgery.

Year of Surgery

- ◯ Abdominal Hysterectomy _____
- ◯ Appendectomy _____
- ◯ Gallbladder _____
- ◯ Colon _____
- ◯ Port Placement _____
- ◯ Hernia Repair _____
- ◯ Back Surgery _____
- ◯ Breast Surgery _____

Year of Surgery

- ◯ Cardiac Surgery _____
- ◯ Splenectomy _____
- ◯ Kidney _____
- ◯ Metal Implant _____

Other Surgery:

_____

- ◯ **I HAVE HAD NO SURGERIES**

ALLERGIES

Please mark all allergies you have.

- ◯ **I HAVE NO KNOWN ALLERGIES**
- ◯ Latex Allergy
- ◯ IV Contrast Allergy
- ◯ Penicillin
- ◯ Erythromycin
- ◯ NSAIDs (aspirin, ibuprofen, naproxen, etc.)
- ◯ Sulfa

Please list all medications or other items that you are allergic to. If possible, include your reactions.
(e.g., hives, rash, itching, headaches, nausea, diarrhea, fainting, shock, shortness of breath, etc.)

Name of Medication or Allergen	Reaction

MEDICATIONS

What medications are you currently taking?
(Include prescription medications, vitamins, over-the-counter medications and herbal supplements.
e.g., Aspirin, Motrin, Vitamin E, St. John's Wort, etc.)

◯ **I AM NOT TAKING ANY MEDICATIONS**

Name of Medication	Dosage	Frequency

Name of Medication	Dosage	Frequency

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ **Date:** _____

Reviewed by: _____ **Date:** _____