PATIENT MEDICAL HISTORY

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| *Name:* | *Birth date:* |
| **PAST MEDICAL HISTORY** |
| **Childhood Illnesses** | Diphtheria |  | Measles |  | Mumps |  | Rheumatic Fever |  |
| Chicken Pox |  | Scarlet Fever |  |  |  |
| **Past Surgeries**(list operations, dates,& complications ) |  |
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| **Serious Adult Illnesses & Hospitalizations**(list dates &complications) |  |
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| **Chronic Medical Problems** | Diabetes |  | Hypertension |  | Ulcers |  | Emphysema |  |
| Cancer |  | Heart Disease |  | Stroke |  | Tuberculosis |  |
| Asthma |  | Kidney Stones |  | Gout |  |  |  |
| Stroke |  | Kidney Disease |  |  |  |  |  |
| **Injury History**(list dates and complications ) | Fractures? |
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| Loss of consciousness? |
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| **Allergies**(list reactions) | Medications |
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| Other |
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| **Current Medications**(list all over-the counter meds and dosages) |  |
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| **FAMILY HISTORY** |
| RELATIVE | PRESENTAGE | PRESENTHEALTH | AGE & CAUSE OF DEATH |
| Father |  |  |  |
| Mother |  |  |  |
| Grandparents |  |  |  |
| Sibling |  |  |  |
| Children |  |  |  |
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| **SOCIAL HISTORY** |
| Birth Date | Birth Place |
| Marital History | Occupation |
| Turmoil (financial, emotional, etc) |
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| **Exercise &****Frequency** |  |
| Habits | Tobacco | Yes |  | No |  | \_\_\_Packs/day | Year Quit |
| Alcohol | Yes |  | No |  | \_\_\_Drinks per day/week/month/yr |
| Caffeine | Yes |  | No |  | \_\_\_Drinks per day/week/month/yr |
| Drugs | Yes |  | No |  | Quit? Type/Frequency |
| Other |  |
| **OTHER PERTINENT MEDICAL HISTORY** |
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| *Signature: Date:* |