



# Patient History and Review

Please fill out the following form so we may best serve your healthcare needs. This information is strictly confidential and will become part of your personal record. Please be as complete as possible.

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Birthdate: \_\_\_\_\_

## PAST MEDICAL HISTORY :

List all past and current medical problems.  
Please include dates.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

## PAST SURGICAL HISTORY:

Please list all past surgeries and dates.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

## ALLERGIES:

Please list all drug, food, and environmental allergies, as well as reaction.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## MEDICATIONS:

Please list all prescription medications and over the counter medications, as well as vitamins, with the dosage and how often they are taken.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

PHARMACY: \_\_\_\_\_

## SOCIAL HISTORY:

1. Highest level of education \_\_\_\_\_
2. Have you ever smoked or used tobacco? \_\_\_\_\_  
If so, how much? \_\_\_\_\_
3. Do you drink alcohol? \_\_\_\_\_  
If so, how much? \_\_\_\_\_
4. Have you ever used illicit drugs? \_\_\_\_\_  
If so, what kind? \_\_\_\_\_
5. Marital status: M S W D
6. Occupation \_\_\_\_\_
7. Children (names/year of birth) \_\_\_\_\_  
\_\_\_\_\_
8. Spouse (name/year of birth) \_\_\_\_\_
9. Pets \_\_\_\_\_ Indoor/outdoor? \_\_\_\_\_
10. Sexual preference? \_\_\_\_\_
11. Have you ever received a blood transfusion?  
\_\_\_\_\_ If yes, what year? \_\_\_\_\_
12. Date of last tetanus injection: \_\_\_\_\_
13. Have you ever had a colonoscopy? \_\_\_\_\_  
If yes, when? \_\_\_\_\_
14. Females, last menstrual period: \_\_\_\_\_

## FAMILY HISTORY:

Please list family members( 1<sup>st</sup> degree relatives only: such as, mom ,dad, siblings,children) with a history of any of the following:

- Diabetes \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Obesity \_\_\_\_\_
- High cholesterol \_\_\_\_\_
- Stroke \_\_\_\_\_
- Heart attacks \_\_\_\_\_
- Seizures \_\_\_\_\_
- Thyroid problems \_\_\_\_\_
- Lung problems \_\_\_\_\_
- Alcoholism \_\_\_\_\_
- Tuberculosis \_\_\_\_\_
- Mental problems \_\_\_\_\_
- Blood Disorders \_\_\_\_\_
- Kidney problems \_\_\_\_\_
- Skin problems \_\_\_\_\_
- Cancer (what type) \_\_\_\_\_

DATE OF EXAM: \_\_\_\_\_