



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.

PAST MEDICAL HISTORY :

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

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

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. _____
9. _____
10. _____

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/ages) _____

 8. Spouse (name/age) _____
 9. Pets _____ Indoor/outdoor? _____
 10. Have you ever had homosexual intercourse?

 11. Have you ever received a blood transfusion?

- If yes, what year? _____

FAMILY HISTORY:

Please list family members(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) _____
- _____

Name: _____

SSN: _____

Date of Exam: _____