PATIENT MEDICAL HISTORY

NAME:_____AGE:_____TODAY'S DATE:_____

OCCUPATION:_____PRESENT:_____RETIRED:_____

PLEASE LIST ALL MEDICATIONS & DOSAGES:_____

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS OR FOODS? YES_____NO_____

IF YES, PLEASE LIST:_____

LIST ALL PAST SURGERIES OR SERIOUS ILLNESS:_____

_____

_____

HAVE YOU EVER BEEN ADVISED TO HAVE ANY SURGICAL OPERATION WHICH WAS NOT PERFORMED? YES___NO___. IF YES, PLEASE EXPLAIN:_____

_____

_____

DO YOU SMOKE?_____HOW MUCH?_____WHEN DID YOU STOP?_____

DRINK ALCOHOL?_____HOW MUCH?_____WHEN STOPPED?_____

HOW PHYSICALLY ACTIVE ARE YOU?_____

FAMILY HISTORY – ILLNESSES – AND/OR CAUSE OF DEATH:

FATHER: _____MOTHER:_____

SIBLING:_____SPOUSE:_____

CHILDREN:_____

ANY FAMILY HISTORY OF:(CIRCLE ALL THAT APPLY & SPECIFY WHO)

CANCER_____DIABETES_____HEART DISEASE_____

HIGH BLOOD PRESSURE_____STROKE_____