Patient Medical/Family History

Patient Name_____**Acct#**_____**SSN**_____
(Full legal name)
Do you have Allergies? Y_____N_____ If yes, please list_____
PLEASE LIST ALL MEDICATION YOU ARE CURRENTLY TAKING (NAME, DOSAGE/STRENGTH, &FREQUENCY)
Name_____**Strength/Dosage**_____**How Often Taken**_____
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PLEASE LIST ALL YOUR SURGICAL PROCEDURES

Procedure_____ **Year**_____ **Procedure**_____ **Year**_____
Procedure_____ **Year**_____ **Procedure**_____ **Year**_____
Procedure_____ **Year**_____ **Procedure**_____ **Year**_____

Have you ever had:	Circle one	
Skin Cancer	Yes	No
Malignant Melanoma	Yes	No
Anemia	Yes	No
Gout	Yes	No
Stroke	Yes	No
Breathing Difficulties	Yes	No
Palpitations	Yes	No
Heart Murmur	Yes	No
Abnormal EKG	Yes	No
Rheumatic Fever	Yes	No
High Blood Pressure	Yes	No
Angina	Yes	No
Heart Attack	Yes	No
Hiatal Hernia	Yes	No
Arthritis	Yes	No
Gallbladder problems	Yes	No
Thyroid problems	Yes	No
Kidney problems	Yes	No
Ulcers	Yes	No
Bowel problems	Yes	No
Psychiatric problems	Yes	No
Liver problems	Yes	No
Other (please specify)	Yes	No

_____

Have you ever had: Circle one
Diabetes Yes No Controlled by:_____
High Cholesterol Yes No Count / When_____
Do you currently use tobacco? Yes_____ No_____
Circle one or more: Cigars Cigarettes Pipe Chewing tobacco
Have you ever used tobacco? Yes_____ No_____
Circle one or more: Cigars Cigarettes Pipe Chewing tobacco
How many years?_____**How much per day?**_____
When did you quit?_____
Please estimate your daily consumption of alcohol_____

Is there anything else we should know about your health or historical background? _____
_____
_____
_____

Family History

Father Living Yes No Age or Age at Death_____ **Cause of Death**_____
Mother Living Yes No Age or Age at Death_____ **Cause of Death**_____

How Many Brothers?_____ **Number Living**_____**Number Deceased**_____**Age&Cause of Death**_____
How Many Sisters? _____ **Number Living**_____ **Number Deceased**_____**Age&Cause of Death**_____

How Many Children?_____ **Ages:**_____ **Any Health problems?**_____
If yes, of what nature?_____
How Many Grandchildren_____

Do any of the following illnesses run in your family?

Skin Cancer	Yes	No	Which Member:_____
Malignant Melanoma	Yes	No	Which Member:_____
Diabetes	Yes	No	Which Member?_____
Stroke	Yes	No	Which Member?_____
Hypertension	Yes	No	Which Member?_____
Heart Disease	Yes	No	Which Member?