

PATIENT MEDICAL HISTORY

Name: _____ **Date-Of-Birth:** ____/____/____ **Age:** ____
(FIRST) (LAST) (MI)

Referring Provider: _____ **Reason for Visit:** _____

Occupation: _____

Medical Problems:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Surgeries/Procedures:

- 1) _____ Year ____
- 2) _____ Year ____
- 3) _____ Year ____
- 4) _____ Year ____
- 5) _____ Year ____

Do your parents, siblings or children suffer from any of the following conditions?

- Asthma? Yes No If Yes, who? _____
- Emphysema? Yes No If Yes, who? _____
- Cancer? Yes No If Yes, who? _____
 Type of Cancer: _____
- Death before age 60? Yes No If Yes, who? _____
 Reason for Death: _____
- Other significant Family History: _____

Smoking History:

- Do you smoke? Yes No Quit Never Amount used per day: ____ Age Started: ____
- If stopped, what age: ____ Recreational Drugs: Yes No Quit

Alcohol Consumption:

- Do you drink alcohol beverages? Yes No Favorite Drink: _____
- How many _____/ Day Week Month

Occupation(s): _____

Have you ever been exposed to any hazardous chemicals, fumes, dust and/or asbestos: Yes No

Do you have Pets: Yes No Type: Dog(s) Cat(s) Bird(s) Other:

Have you had Flu Shot this year? Yes No **Pneumonia Shot?** Yes No When? _____

CONTINUED ON THE NEXT PAGE

Medication Allergies: None _____

Medications: (Include Birth Control Pills, Herbals, Vitamins, Dietary Supplements and Over-The-Counter medications.) None

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

11) _____

12) _____

13) _____

14) _____

15) _____

The above information is current and correct to the best of my knowledge:



X _____
Signature of Patient/Patient Representative

____/____/2013