



Patient Medical History

Name: _____ Date of Birth: _____

Allergies to Medications: _____
Allergies: _____

Have you ever had a: Flu Shot: ___yes ___no Shingles vaccine: ___yes ___no
Pneumonia vaccine: ___yes ___no

Are you currently taking any medications or vitamins and supplements? ___yes ___no
If yes, please list dosages and times taken:

Please list any surgeries/hospitalizations and dates:

List and describe past medical problems:

Family Medical History: please list any past illnesses or diseases in your family

Father: Age: _____ Age at death: _____ illness or cause: _____
Mother: Age: _____ Age at death: _____ illness or cause: _____
Brother: Age: _____ Age at death: _____ illness or cause: _____
Brother: Age: _____ Age at death: _____ illness or cause: _____
Sister: Age: _____ Age at death: _____ illness or cause: _____
Sister: Age: _____ Age at death: _____ illness or cause: _____

Social/Personal History:

Tobacco Use: Do you smoke? ___yes ___no
If yes, packs a day _____, for _____years. Have you quit? ___yes ___no. If yes, for how long? _____
Do you drink caffeine? ___none ___minimal ___moderate ___excessive
Do you drink alcohol? ___none ___minimal ___moderate ___excessive
Is your work...? ___sedentary ___normal ___labor intensive ___retired
Do you exercise? ___yes ___no If yes, how many times per week? _____

Reason for today's visit?



At any time have you ever had any of the following?

Respiratory issues? _____

Difficulty breathing ___yes ___no Asthma ___yes ___no Constant Cough: ___yes ___no

Cardiovascular issues: _____

Hypertension: ___yes ___no Chest Pain: ___yes ___no Heart Murmurs: ___yes ___no

Gastrointestinal Issues: _____

Heart Burn: ___yes ___no Change in bowel habits: ___yes ___no Pain with urination: ___yes ___no

Kidney infections: ___yes ___no Back Pain: ___yes ___no Joint pain: ___yes ___no

Central Nervous System: _____

Blackouts: ___yes ___no Headaches: ___yes ___no Numbness: ___yes ___no

Endocrine: _____ Diabetes: ___yes ___no

Eyes: _____

Glaucoma: ___yes ___no Cataracts: ___yes ___no Hearing Loss: ___yes ___no

Is there anything else about your medical history that you would like us to be aware of:
