Name:_____ DOB_____

FAMILY MEDICAL HISTORY

Check boxes if family members have had the following conditions.

	Father	Mother	Brother	Sister	Father's Father	Mother's Father	Father's Mother	Mother's Mother
Colon cancer								
Diabetes								
Gallbladder disease								
Heart disease								
High Blood Pressure								
Stroke								
Thyroid Disease								
Adverse Reaction to Anesthesia								
Alcoholism								
Allergies								
Alzheimer's Disease								
Anxiety								
Arthritis								
Asthma								
Bleeding Problems								
Cancer (what type)								
Colon Polyps								
Congestive heart failure								
COPD (emphysema)								
Dementia								
Depression								
Glaucoma								
Heart attack								
HIV infection								
Kidney Disease								
Liver Disease								
Lung Disease								
Mental disorders								
Migraine headaches								
Seizure disorder								
Sickle cell anemia								
Sickle cell trait								
Substance (drug) abuse								

List other Medical Conditions:

CHIEF COMPLAINT/LOCATION/CURRENT SYMPTOMS

_____

_____

PHARMACY NAME AND NUMBER_____

LIST ALL MEDICATIONS AND DOSAGES_____

_____

_____

MEDICATION ALLERGIES / INTOLERANCES TO _____

_____

_

	Yes	No	ARE YOU TAKING THE FOLLOWING? IF YES, WHY?		
ARE YOU ALLERGIC TO IV DYE?	□	□	Asprin	yes □	no □
ARE YOU ALLERGIC TO LATEX?	□	□	Coumadin	yes □	no □
DO YOU SMOKE?	□	□	Plavix	yes □	no □
IF YES, HOW MANY PACKS?	_____		Pradaxa	yes □	no □
FORMER SMOKER?	□	□	Xarelto	yes □	no □
DO YOU DRINK?	□	□			
DO YOU USE ILLICIT DRUGS?	□	□	Reason for		Outcome

Past medical history

check all the apply

□ ACNE □ AS	□ DIABETES	□ MULTIPLE SCLEROSIS	HAVE YOU HAD
□ ANXIETY DISORDER	□ DIALYSIS	□ OVARIAN CANCER	□ COLONOSCOPY
□BASAL CELL SKIN CANCER	□ GALLSTONES	□ OVARIAN CYST	DATE_____
□ BLADDER INFECTIONS	□ GASRTIC CANCER	□ PARALYSIS	□ MAMMOGRAM
□ BLOOD CLOTS/ DVT	□ GOITER	□ PARKINSON'S DISEASE	DATE_____
□ BREAST CANCER	□ HEART ATTACK	□ PSORIASIS	□ PAP SMEAR
□ CERVICAL CANCER	□ HEART VALVE DISEASE	□ COPD / ASTHMA	DATE_____
□ CERVICAL DISC DISEASE	□ HIATAL HERNIA	□ QUADROPLEGIA	□ MASTECTOMY
□COLON CANCER DATE	□ HIGH BLOOD PRESSURE	□ SEIZURES	DATE_____
□ DECUBITIS ULCER	□ HYPOTHYROIDISM	□ SKIN CANCER	□ HYSTERECTOMY
□ DEMENTIA	□ KIDNEY DISEASE	□ SKIN ULCER	DATE_____
□ DEPRESSION	□ LUMBAR DISC DISEASE	□ UTERINE CANCER	□ COLECTOMY
□ DERMATITIS	□ LUNG CANCER	□ UTERINE FIBROIDS	DATE_____
	□ MELANOMA – SKIN	□ OBSTRUCTIVE SLEEP DISORDER	
	□ MIGRAIN HEADACHES		

LIST PAST SURGICAL HISTORY

_____

_____

_____

_____

_____

FAMILY PHYSICIAN / PCP ADDRESS PHONE NUMBER

Signature (parent or Gaurdian) DATE