MEDICAL HISTORY

NAME_____ DATE OF BIRTH _____ /____/_____

HEALTH MAINTENANCE	MONTH/YR		MONTH/YR
COLONOSCOPY		FLU VACCINE	
COLORECTAL SCREENING		MAMMOGRAM	
ENDOSCOPY		PAP SMEAR/PELVIC SCREENING	

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING: (PLEASE CHECK)

	ASTHMA			HIGH BLOOD PRESSURE	
	BLEEDING DISORDER			HIGH CHOLESTEROL	
	BLOOD CLOTS/ PHLEBITIS			KIDNEY DISEASE/ STONES	
	CANCER			HISTORY OF SEIZURE	
	COPD/ EMPHYSEMA			SLEEP APNEA	
	DIABETES			HISTORY OF STROKE	
	DEPRESSION/ ANXIETY			THYROID DISEASE	
	HEART DISEASE/ HEART ATTACK			PACEMAKER/DEFIB	

YEAR	SURGERIES/ HOSPITALIZATIONS
# OF	PREGNANCIES C-SECTIONS

PLEASE LIST MEDICATIONS AND VITAMINS IN THE SPACES BELOW:

CONSENT TO CHECK MEDICATION HISTORY? PLEASE INITIAL YES _____ NO _____

LIST ALL ALLERGIES TO MEDICATION:	REACTION:

FAMILY HISTORY OF: CANCER, HEART DISEASE, DIABETES

FATHER	
MOTHER	
BROTHER	
SISTER	

*****SMOKING STATUS: ☐ CURRENT ☐FORMER/DATE QUIT_____ ☐NEVER*****

HEIGHT_____ WEIGHT_____ BLOOD PRESSURE_____