

Personal Past Medical History

Name _____ Date of Birth _____ Date _____
Last First Middle Mo. Day Yr.

Referred by _____ Doctor last seen _____ When _____ Why _____

Reason seeing doctor today: _____

Have you ever had: (circle and give date of onset)

| | | | |
|--------------------|----------------------|--------------------|------------------|
| Anemia | Epilepsy (seizures) | Digestive problems | Rheumatic fever |
| Asthma | Fainting spells | Kidney disease | Thyroid problems |
| Arthritis/Gout | Gall bladder disease | Liver disease | Tuberculosis |
| Cancer | Headaches, severe | Peptic ulcer | Venereal disease |
| Diabetes mellitus | Heart disease | Phlebitis | Other _____ |
| Emotional disorder | High blood pressure | Pneumonia | Other _____ |

Have you for health reasons ever been denied the following: (circle and tell why)

Life insurance _____ Employment _____ Military Service _____

Past Medical History:

| Surgery/Operations | Reason | Date | Hospital & Doctor |
|--------------------|--------|------|-------------------|
| | | | |
| | | | |
| | | | |
| | | | |

Health Habits:

| | | |
|------------------|-----|-----|
| | Yes | No |
| Breast Self Exam | ___ | ___ |
| Exercise | ___ | ___ |
| Good Nutrition | ___ | ___ |
| Seat Belts | ___ | ___ |

Non-Surgical Hospitalizations

| Illness/Injury | Date | Hospital & Doctor |
|----------------|------|-------------------|
| | | |
| | | |
| | | |
| | | |

Substance Usage:

| | |
|--------------|--------------|
| | Amount Daily |
| Alcohol | _____ |
| Coffee/Tea | _____ |
| Street Drugs | _____ |
| Tobacco | _____ |

Immunizations:

| | | | |
|------------------------------|------|-----------------|------|
| | Date | | Date |
| Small pox _____ | | Measles _____ | |
| Tetanus _____ | | Flu _____ | |
| Polio _____ | | Pneumovax _____ | |
| Ger. Measles (Rubella) _____ | | | |

Screening Procedures:

When did you last have:

| | |
|---------------|-------|
| Cholesterol | _____ |
| EKG | _____ |
| Mammogram | _____ |
| Pap Smear | _____ |
| Physical | _____ |
| Sigmoidoscopy | _____ |

| | | | | |
|--------------------------|----------|----------|----------|----------|
| | Medicine | Reaction | Medicine | Reaction |
| Allergies & Side Effects | _____ | _____ | _____ | _____ |
| To Medications: | _____ | _____ | _____ | _____ |

Family Medical history:

| | Living | Dead | Age(s) | Health | If deceased, cause of death |
|----------|--------|------|--------|--------|-----------------------------|
| Spouse | | | | | |
| Children | | | | | |
| Father | | | | | |
| Mother | | | | | |
| Brothers | | | | | |
| _____ | | | | | |
| _____ | | | | | |
| Sisters | | | | | |
| _____ | | | | | |
| _____ | | | | | |

Have any of your blood relatives had the following:

- (Circle)
- | | |
|--------------------------------|---------------------------|
| Diabetes | Thyroid disorders |
| Stroke | Epilepsy or seizures |
| Cancer | Bleeding disorders |
| Arthritis | Kidney disease |
| Blood disease | High blood pressure |
| Heart disease | Tuberculosis/Lung Disease |
| Peptic Ulcers | Emotional disorders |
| Hay fever (asthma, or allergy) | Neurological disorders |