PATIENT HISTORY

NAME: _____ DOB: ____-____-____ DATE: ____-____-____

LAST MAMMOGRAM: ____-____-____ LOCATION: _____

LAST COLONOSCOPY: ____-____-____ LOCATION: _____

DRUG ALLERGIES

__ NO KNOW ALLERGIES

CURRENT MEDICATION

__ NONE

FAMILY HISTORY

	FATHER	MOTHER	FATHERS PARENTS	MOTHERS PARENTS	SIBILINGS	CHILDREN
HEART DISEASE						
HIGH BLOOD PRESSURE						
STROKE						
CANCER (TYPE)						
GLAUCOMA						
DIABETES						
EPILEPSY						
BLEEDING DISORDER						
KIDNEY DISORDER						
THYROID DISORDER						
MENTAL ILLNESS						
OSTEOPOROSIS						

MEDICAL HISTORY

__ Headaches
__ Shortness of Breath
__ Heart Palpitations
__ Heart Murmur
__ Chest Pain
__ Dizziness
__ Peripheral/Vascular Disease
__ Allergies/Hay Fever
__ Bronchitis

__ Pneumonia
__ Ulcer
__ GI Disorder
__ Lactose Intolerance
__ Gallbladder Disease
__ Prostate Disease
__ Bowel Irregularity
__ Sexual/Menstrual Dysfunction
__ Venereal Disease

__ Diabetes
__ Hepatitis
__ Anemia
__ Arthritis
__ Osteoporosis
__ Hypertension
__ Depression
__ Gout
__ Stroke
__ Cancer

__ Rheumatic Fever
__ Glaucoma
__ Epilepsy
__ Bleeding Disorder
__ Kidney Disease
__ Thyroid Disease
__ Mental Illness
__ Impairments
__ Other: _____

__ NO KNOW HISTORY

HOSPITILIZATIONS OR SURGERIES

REASON	DATE	REASON	DATE

__ NOT APPLICABLE

HABITS

TOBACCO USE

Smoke cigarettes: __ Never __ NO __ YES
Current smoker: __ Pipe __ Cigar __ Snuff __ Chew
Packs/day: _____ # of years: _____

ALCOHOL USE

Do you drink alcohol? __ YES __ NO
# of drinks a week: ____
___ Beer ___ Wine ____ Liquor

DRUG USE

Do you use marijuana or recreational drugs: __ YES __ NO
Have you every used needles to inject drugs: __ YES __ NO

SEXUAL PREFERENCE

___ Male ___ Female ____ Both male & female

Last Menstrual Cycle: ____-____-____