

Patient Name: _____

Date of Birth: _____

Please place check mark in "current" column if you are presently being treated for the problem.

Please place check mark in "past" column if the problem has been resolved.

MEDICAL HISTORY	CURRENT	PAST	MEDICAL HISTORY	CURRENT	PAST	MEDICAL HISTORY	CURRENT	PAST
No Significant Medical History			Diverticulitis			Melanoma		
Abnormal Pap Smear			Diverticulosis			Migraine Headache		
Alcohol Abuse			Emphysema			Nephrolithiasis(Kidney Stone)		
Anxiety Disorder			Esophageal Reflux(Heartburn)			Obstructive Sleep Apnea		
Asthma			Gestational Diabetes			Opiod Abuse(Narcotic)		
Atrial Fibrillation			Gout			Osteoarthritis		
Breast Cancer			HIV/AIDS			Osteoporosis		
Colon Cancer			Hypercholesterolemia			Prostate Cancer		
Congestive Heart Failure			Hypertension			Rheumatoid Arthritis		
Coronary Artery Disease			Hypothyroidism			Seizure Disorder		
Dementia			Irritable Bowel Syndrome			Stroke		
Depression			Lung Cancer			Tension Headaches		
Diabetes Mellitus			Lyme Disease			Other		

Please place a check mark only for surgeries that apply to you in the first column. In the second column, please enter the year if known.

SURGICAL HISTORY	YEAR	SURGICAL HISTORY	YEAR	SURGICAL HISTORY	YEAR
Appendectomy(appendix)		Knee Surgery(other)		Tonsillectomy	
Breast Lumpectomy		Lower Back Surgery		Total Hip Replacement	
Breast Mastectomy		Oopherectomy(ovary removal)		Tubal Ligation	
Carotid Surgery(endarterectomy)		single <input type="checkbox"/>		Umbilical Hernia Repair	
Cataract Surgery		both <input type="checkbox"/>		Vaginal Hysterectomy	
Cesarean Section		Prostate Surgery		Vasectomy	
Cholecystectomy(gallbladder)		Shoulder Surgery		Other	
Coronary Artery Bypass(heart)		Total Abdominal Hysterectomy			
Inguinal Hernia Repair		ovary removal <input type="checkbox"/>			
Knee Replacement		ovaries remain <input type="checkbox"/>			

Please place a check mark only for items that apply to you in the first column.

SOCIAL HISTORY			
Alcohol-social drinker			Occupation-please describe
Caffeine Use			Parentage
Drug Use			# daughters
Smoking			# sons
currently <input type="checkbox"/>	packs per day _____	# years smoked _____	Sexually Active
previously <input type="checkbox"/>	year quit _____		History of Abuse-circle one
Never Smoked			physical, emotional,sexual
Exercise Regularly			Uses Seatbelts
Sedentary	currently on disability: yes _____ no _____		Yes
Marital Status-circle one	Single, Married, Divorced, Separated, Widowed, Same Sex Partner		No
Employment History-circle one	Fulltime, Parttime, Unemployed, Disabled, Retired		Smoke Detectors in home
			Yes
			No
			Uses motor/bike helmet
			Yes
			No

Date: _____

Provider Reviewed: _____