Today's Date: _______/___________/__________

Patient's Full Name: ________________________________Birth Date: ______/_________/________
Allergies: (food, medication, other) _______________________________________ [ ] none

Patient and Family Medical History

("Family" includes parents, grandparents, siblings, and children of the patient, Please specify which side of family, mom or dad side)

				Who?
Heart Attack / Heart Disease	N	Y – Me	Y – My Family	______________________
High Cholesterol	N	Y – Me	Y – My Family	______________________
Rheumatic Fever	N	Y – Me		
High Blood Pressure	N	Y – Me	Y – My Family	______________________
Blood Clot (in Lungs / Legs)	N	Y – Me	Y – My Family	______________________
Blood / Bleeding Disorders	N	Y – Me	Y – My Family	______________________
Asthma	N	Y – Me	Y – My Family	______________________
Other Lung Problems/Disease	N	Y – Me	Y – My Family	______________________
Tuberculosis	N	Y – Me	Y – My Family	______________________
Diabetes	N	Y – Me	Y – My Family	______________________
Liver Disease	N	Y – Me		
Stomach/Gall Bladder/Bowel Prob.	N	Y – Me		
Thyroid Problems	N	Y – Me	Y – My Family	______________________
Bladder/Kidney Problems	N	Y – Me		
AIDS (HIV)	N	Y – Me	Y – My Family	______________________
Hepatitis (Type __)	N	Y – Me	Y – My Family	______________________
Anemia or Blood Disorder	N	Y – Me	Y – My Family	______________________
Blood Clots (Lungs or Legs)	N	Y - Me	Y - My Family	
Blood Transfusion	N	Y – Me		
Autoimmune Disease like Lupus	N	Y – Me	Y – My Family	______________________
Allergies	N	Y – Me		
Breast Problems	N	Y – Me	Y – My Family	______________________
Cancer	N	Y – Me	Y – My Family	______________________
Stroke	N	Y – Me	Y – My Family	______________________
Infertility	N	Y – Me		
Female or Sexual Problems	N	Y – Me		
Sexually Transmitted Infection	N	Y – Me		
Birth Defects or Inherited Diseases	N	Y – Me	Y – My Family	______________________
Seizures	N	Y – Me	Y – My Family	______________________
Migraine Headaches	N	Y – Me	Y – My Family	______________________
Degenerative Disease (like MS)	N	Y – Me	Y – My Family	______________________
Mental Illness / Depression	N	Y – Me	Y – My Family	______________________
Physical/Emotional Abuse/Neglect	N	Y – Me	Y – My Family	______________________
Addiction - Drugs/Alcohol/Nicotine	N	Y – Me	Y – My Family	______________________
Major Accidents	N	Y – Me		
Complications from anesthesia	N	Y – Me	Y – My Family	______________________
Other Medical Problems	N	Y – Me	Y – My Family	______________________
No Known Medical Problems	N	Y – Me	Y – My Family	______________________
Hospitalization other than surgery	N	Y – Me		

Patient's Full Name: ______________________________Birth Date: ______/_________/________

If you answered "yes" to any of the above medical problems, please describe the problem(s):_________
____
____
____
____
____
____
____

Please list any surgeries you've had: ____
____

Do you ever use/ take:

Alcohol	N	Y -- Amount per day/ week________
Tobacco	N	Y-- Amount per day/ week________
Medications not prescribed to you	N	Y-- What? ______________________
Street Drugs	N	Y—What? _____________________

Please list all herbs, vitamins, and supplements you are taking: ____________________________
____
Please list all over-the-counter medicines you take (Tylenol, Motrin, aspirin, etc) __________________
____
Please list all prescription medicines you are taking, how much, and how often
____
____