

Family HX Medical Hx General Information

Medical History

Name: _____

Date: _____

Please describe the reason for your visit to our office today : _____

Please list your present medications including blood thinners/anticoagulants: _____

Please list any allergies to any medications: _____

Please list and describe any surgeries, hospitalizations or serious medical problems you have:

Are you pregnant or nursing a child? Y/N Do you smoke? Y/N If yes: How long? _____
Do you regularly drink alcohol? Y/N Do you drink coffee? Y/N
If yes: How much? _____ If yes: How many cups per day? _____

Do you have any of the following? (Please Check all that apply):

- | | | | | |
|--------------------|------------------|------------------|--------------------|----------------|
| ___ Chest Pain | ___ Hypertension | ___ Heart Attack | ___ Stroke | ___ Headaches |
| ___ Glaucoma | ___ Allergies | ___ Memory Loss | ___ Hemorrhoids | ___ Asthma |
| ___ Dizzy Spells | ___ Cancer | ___ Diabetes | ___ Arthritis | ___ Gallstones |
| ___ Cataracts | ___ Stomach Pain | ___ Kidney | ___ TB | ___ Ulcers |
| ___ Skin Disorders | ___ Hepatitis | ___ Depression | ___ Blood in Stool | ___ Other |

Do you have a family history of any of the following? (Please list who)

High Blood Pressure _____ Breast Cancer _____ Ovarian
Cancer _____
Cervical Cancer _____ Diabetes _____ Heart Attack

Reviewed by: _____ M.D. on _____