PATIENT HISTORY

ID _____

Fill in the WHITE SPACES completely. Use the back of this page if more space is needed
Do not fill in grayed out sections - these should be completed by the office staff.

/ /		/ /
TODAY'S DATE	**NAME**	**DOB**

MEDICAL HISTORY	**SURGICAL HISTORY**
List any current or past medical conditions	*List any past surgeries / procedures*

MEDICATION LIST

*List **all medications** you are currently taking with the **dose** and **instructions**(ex: twice a day) Include OTC med, vitamins, and supplements.*

ALLERGIES *List any medication allergies and reactions*	

SOCIAL HISTORY

Marital Status		*Occupation*	
How often do you wear a seatbelt while in the car? (always/sometimes/never)			
What kind of regular exercise do you do?			
How often do you exercise?			
Do you currently use drugs?		*How much? (ex: daily, monthly, yearly)*	
Do you currently drink alcohol?		*How much? (ex: daily, monthly, yearly)*	
Do you currently use tobacco? (cigarettes, cigars, e-cigarettes, vapes, chewing tobacco, etc.)		*How much? (ex: daily, monthly, yearly)*	
Do you currently consume caffeine? (tea, coffee, soda, etc.)		*How much? (ex: daily, monthly, yearly)*	

FAMILY HISTORY

FAMILY MEMBER	*AGE (current/at death)*	*MEDICAL PROBLEMS*
Mother		
Father		

IMMUNIZATION & SCREENING HISTORY

List the most recent date for each below (if applicable)

Immunizations	*Tetanus*		*Flu*		*Pneumonia*		*Shingles*		*HPV*		*Hep A*		*Hep B*	
Colonoscopy			*Test for Blood in Stool*											
MEN ONLY	*PSA (blood test)*				*Rectal/Prostate Exam*									
WOMEN ONLY	*Menses/Period*		*Pap*		*Mammogram*									
	Bone Density		*Age @ 1st Period*		*# of Pregnancies*									
	# of Live Births		*# of Miscarriages*		*# of Abortions*									