

# Confidential Medical History

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Other Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Current Medications: **Include** Over the Counter Medication & Vitamins (continue on back of sheet if needed)

Name, Dosage and Frequency: \_\_\_\_\_

Name, Dosage and Frequency: \_\_\_\_\_

Name, Dosage and Frequency: \_\_\_\_\_

Name, Dosage and Frequency: \_\_\_\_\_

Long Term Medical Problems **Include** Year of Diagnosis: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Past Surgeries **Include** Approx. Year: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# of Children: \_\_\_\_\_ # of Pregnancies: \_\_\_\_\_ Method of Contraception: \_\_\_\_\_

Social Habits: Check all that apply and describe amounts and frequency (use N/A if not applicable)

Tobacco \_\_\_\_\_  Alcohol \_\_\_\_\_  Drugs \_\_\_\_\_

Exercise \_\_\_\_\_  Special Diet \_\_\_\_\_  Sexual Activity \_\_\_\_\_

Family History:      Living?      Age/Age at Death      Health Issues/Cause of Death

Father \_\_\_\_\_

Mother \_\_\_\_\_

Siblings \_\_\_\_\_

Siblings \_\_\_\_\_

Health Maintenance: Please indicate the year you last had the following test or exam (if not done, leave blank)

Cholesterol \_\_\_\_\_ Glucose \_\_\_\_\_ TB(skin) \_\_\_\_\_ Eye \_\_\_\_\_ Dental \_\_\_\_\_ Bone Density \_\_\_\_\_

Prostate \_\_\_\_\_ Pap Smear \_\_\_\_\_ Mammogram \_\_\_\_\_ Colonoscopy or Flex Sig \_\_\_\_\_

Immunizations: Please indicate the year you last had the following immunization (if not done, leave blank)

Tetanus \_\_\_\_\_ Flu \_\_\_\_\_ Pneumonia \_\_\_\_\_ Shingles \_\_\_\_\_ Hep A \_\_\_\_\_ Hep B \_\_\_\_\_ Other \_\_\_\_\_