



PATIENT MEDICAL HISTORY

Patient Name	Date of Birth
Current Medications Patient is Taking	
What allergies do you have (drugs, food, etc.)?	
<p><i>Past Medical History</i></p> <p>Date of Last Examination: ____/____/____</p> <p>Have you ever been hospitalized (Check one)? ____ Yes ____ No</p> <p> If yes, what for? _____</p> <p>Have you ever been tested for Hepatitis A, B, or C (Check one)? ____ Yes ____ No</p> <p>Which Hepatitis did you get tested for? ____ A ____ B ____ C</p> <p>What were the results? ____ Positive ____ Negative</p> <p>Have you been vaccinated for Hepatitis A? ____ Yes ____ No</p> <p> If yes, please list date vaccine series completed: ____/____/____</p> <p>Have you been vaccinated for Hepatitis B? ____ Yes ____ No</p> <p> If yes, please list date vaccine series completed: ____/____/____</p> <p>Date of last Tuberculosis (TB) Screening? ____/____/____</p> <p> Result TB Screening: ____ Positive ____ Negative</p> <p> If Positive TB Screen, Date of Last Chest X-Ray: ____/____/____</p> <p> Result of Chest X-Ray: ____ Positive ____ Negative</p> <p>Have you ever been diagnosed with a sexually transmitted disease? ____ Yes ____ No</p> <p>List diagnosed sexually transmitted disease(s): _____</p>	
Please describe any current or past medical treatment(s):	
Please list your past surgeries including cosmetic surgeries:	

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Social and Preventative History

Circle one: Single Married Domestic Partnership Divorced Widowed

Prehospital Do Not Resuscitate (DNR)

If your heart stopped and you stopped breathing, would you want us to perform CPR on you? (Check one) Yes No

Primary language spoken and written? _____

Do you currently smoke cigarettes and/or chew tobacco? (Check one) Yes No

If yes, how often and how many packs per day? _____

If no, have you in the past smoked cigarettes and/or chewed tobacco? Yes No

Do you drink alcohol, beer or wine? Yes No

If yes, how many drinks per week? _____

If no, have you drank alcohol, beer or wine in the past? Yes No

Do you currently drink caffeinated drinks (coffee, tea, coca-cola, energy drinks)?

Yes No

If yes, how many cups per day? _____

Do you exercise daily/weekly? Yes No

Do you always use your seatbelt when you are driving? Yes No

Do you wear a helmet when you ride a bicycle or motorcycle? Yes No

Family History

Is your biological mother still alive? Yes No

Current age or age of death: _____

Illness or cause of death: _____

Is your biological father still alive? Yes No

Current age or age of death: _____

Illness or cause of death: _____

Gynecological History (Females Only)

How many times have you been pregnant? _____

How many live births have you had? _____

Date of last Pap Smear? ____/____/____

Have you ever had an abnormal Pap Smear? Yes No

Diagnosis: _____ Follow Up: _____

Have you ever had a sexually transmitted disease? Yes No

Diagnosis: _____

Date of last mammogram: ____/____/____

Mammogram results: _____

Have you ever had a breast biopsy? Yes No

If yes, results: _____

By signing below, I hereby certify that to the best of my know ledge, all the information I have provided on this form is complete, true and accurate.

Patient Signature or Parent/Guardian or Legal Representative of Patient

Date

If Parent/Guardian or Legal Representative of Patient, please state relationship

Revised 11/8/10

