MEDICAL HISTORY

NAME_____ DATE OF BIRTH _____ /____/_____

HEALTH MAINTENANCE	MONTH/YR		MONTH/YR
COLONOSCOPY		PAP SMEAR	
ENDOSCOPY		PNEUMOCOCCAL VACCINE	
MAMMOGRAM		FLU VACCINE	

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING: (PLEASE CHECK)

	ASTHMA			HIGH BLOOD PRESSURE	
	BLEEDING DISORDER			HIGH CHOLESTEROL	
	BLOOD CLOTS/ PHLEBITIS			KIDNEY DISEASE/ STONES	
	CANCER			HISTORY OF SEIZURE	
	COPD/ EMPHYSEMA			SLEEP APNEA	
	DIABETES			HISTORY OF STROKE	
	DEPRESSION/ ANXIETY			THYROID DISEASE	
	HEART DISEASE/ HEART ATTACK			PACEMAKER/DEFIB	

YEAR	SURGERIES/ HOSPITALIZATIONS
# OF	PREGNANCIES C-SECTIONS

MEDICATIONS AND VITAMINS

CONSENT TO CHECK MEDICATION HISTORY: YES_____ NO_____(PLEASE INITIAL)

LIST ALL ALLERGIES TO MEDICATION:	REACTION:

FAMILY HISTORY OF: CANCER, HEART DISEASE, DIABETES

MOTHER	
FATHER	
BROTHER	
SISTER	

SMOKING STATUS: ☐ CURRENT ☐FORMER/DATE QUIT_____ ☐NEVER

HEIGHT_____ WEIGHT_____ BLOOD PRESSURE_____