



Medical History

Patient: _____ Date of Birth: _____ Date: _____

A) What brings in today? _____

B) What medical conditions do you have?

1- _____ 5- _____ 9- _____

2- _____ 6- _____ 10- _____

3- _____ 7- _____ 11- _____

4- _____ 8- _____ 12- _____

C) Please list any diseases in your close family?

Mother:

Sisters:

Father:

Brothers:

D) Please list current medication and dosages?

1- _____ 5- _____ 9- _____

2- _____ 6- _____ 10- _____

3- _____ 7- _____ 11- _____

4- _____ 8- _____ 12- _____

E) Please list allergies to medicines and type of reaction?

1- _____ 3- _____ 5- _____

2- _____ 4- _____ 6- _____

F) Please check the box if you have recently experienced any of the following:

Headache Dizziness Lightheadedness Numbness Tingling

Decreased energy level Depressed mood Snoring

Nausea Vomiting Constipation Diarrhea Black stools

Chest pain Palpitation Cough Shortness of breath

Frequent urination Burning with urination Dribbling

Decreased sexual interest Decreased sexual performance

G) Have you had cancer screening procedures?

Colonoscopy yes/no/not applicable when

Mammogram yes/no/not applicable when

Pap smear yes/no/not applicable when

Prostate exam yes/no/not applicable when

Skin cancer screen yes/no/not applicable when