# Medical History

**Medical** ☐ None (High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

**Surgical** ☐ None (Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.)

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

**Allergies** to medications? ☐ None (If yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.)

_____
_____

**Current prescription medicines** ☐ None

Name of Drug mg dose # times per day

_____
_____
_____
_____
_____
_____
_____

**Current prescription medicines** ☐ None

Name of Drug mg dose # times per day

_____
_____
_____
_____
_____
_____
_____

**"Over the Counter" medicines or Other** (Aspirin, Tylenol, Ibuprofen, Aleve, vitamins and herbals.)

_____ _____ _____ _____
_____ _____ _____ _____

# Family History

Father: ☐ Living – Age: _____ ☐ Deceased, Age at Death _____ (Cause) _____
Mother: ☐ Living – Age: _____ ☐ Deceased, Age at Death _____ (Cause) _____
Siblings: Number Living _____ Number deceased _____ (Cause) _____
Children: Number Living _____ Number deceased _____ (Cause) _____
List other illnesses in your family (Example – Diabetes, heart disease, colon cancer, breast cancer, prostate cancer, etc.)

Family Member Illness Family Member Illness Family Member Illness

_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____

# Social History

**Smoke?** ☐ Yes ☐ No If yes, how much? _____# of packs/day _____ # of years When did you stop smoking? _____
**Alcohol?** ☐ Yes ☐ No If yes, how much? _____

**Exercise** regularly ☐ Yes ☐ No If yes, what and how frequently? _____
Routinely wear **seatbelts?** ☐ Yes ☐ No Do you wear helmets? ☐ Yes ☐ No

Physician Notes:

Physician sign/date: _____
Physician sign/date: _____
Physician sign/date: _____
Physician sign/date: _____