Patient History Form

Name: ________________________________ Date of birth: ____________________

Current medications: ____

Medication allergies: ____

Surgeries: ____

____

Personal/Family medical history: (Place an X if applicable)

	Self	Mother	Father	Brother	Sister	Other
Asthma						
Alcoholism						
Heart disease						
Cancer | Type:						
Depression						
Diabetes						
High cholesterol						
High blood pressure						
Mental illness						
Migraines						
Obesity						
Seizures						
Stroke						
Other conditions:						

Social History

Marital status: ______________________ Spouse name: ______________________

Smoker: ____ Y_____ N _____Former _____Year quit: _____________

If yes, what type (cigarettes, cigars, etc.)? ______________ How much per day?_____________

Drink alcohol: Y _____ N _____ If yes, how much per day?___________________

Seat belt use: Y _____ N _____

Females only:

Number of births: ________ Delivery method: Vaginal ________ C-section __________

Date of last pelvic/pap smear: _____________ Date of last mammogram: _____________