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PATIENT PAST MEDICAL HISTORY FORM CHART# _____

NAME: _____ AGE: _____ DOB: _____ DATE: _____

PRIMARY CARE PHYSICIAN: _____ PRIMARY PHARMACY: _____

REASON YOU ARE HERE: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?

CIRCLE AND GIVE DATES:

Heart Attack _____ Asthma _____ Arthritis _____ Heart Failure _____ Emphysema
 _____ Unplanned weight loss _____
 Heart Disease _____ TB _____ Enlarged lymph nodes _____
 High Blood Pressure _____ Pneumonia, severe _____ Blood Thinner _____
 Poor Circulation _____ Hiatal Hernia _____ Severe Heart Burn _____
 High Cholesterol _____ Stomach Ulcers _____ Hepatitis _____
 Stroke _____ Jaundice _____ Kidney Infection _____ Kidney issues _____
 Severe Headaches _____ Thyroid Problems _____ Diabetes _____
 Seizures _____ Blackout Spells _____ Head Injury _____ Meningitis _____

OTHER PROBLEMS NOT LISTED _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

PENICILLIN _____ SULFA _____ ASPIRIN _____ CODEINE _____ TETANUS _____
DEMEROL _____ "MYCINS" _____ OTHER _____

PLEASE LIST ANY SURGERIES:

SURGERY	DATE	HOSPITAL	SURGEON

CIRCLE THE FOLLOWING THAT APPLY:

SINGLE MARRIED DIVORCED WIDOWED SMOKE? DRINK ALCOHOL?

FAMILY HISTORY-CIRCLE THAT APPLY:

HEART DISEASE DIABETES HIGH BLOOD PRESSURE CANCER STROKE

MOTHER LIVING? _____

FATHER LIVING? _____

LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING:

