# PATIENT MEDICAL HISTORY

Date: _____

Name: _____ DOB: _____

## MEDICAL HISTORY (Check the appropriate box)

| Have you or any members of your family had: | You | Your Family |
|---|---|---|
| 1. High Cholesterol…… | □ | □ |
| 2. Heart Disease…….. | □ | □ |
| 3. Diabetes…… | □ | □ |
| 4. High Blood Pressure…… | □ | □ |
| 5. Asthma…….... | □ | □ |
| 6. Tuberculosis…… | □ | □ |
| 7. Rheumatic Fever…… | □ | □ |
| 8. Thyroid Disease……. | □ | □ |
| 9. Liver Disease…….. | □ | □ |
| 10. Stomach, Bowel or Gall Bladder Problems…….....□ | | □ |
| 11. AIDS (HIV)…..…… | □ | □ |

| | You | Your Family |
|---|---|---|
| 15. Blood Transfusion…… | □ | □ |
| 16. Allergies……. | □ | □ |
| 17. Breast Problems…….. | □ | □ |
| 18. Cancer…….. | □ | □ |
| 19. Birth Defects or Inherited Diseases…….. | □ | □ |
| 20. Other Medical Problems…… | □ | □ |
| 21. No Known Medical Problems | □ | □ |
| 22. Are You Pregnant…… | □ | □ |
| 23. Do You Plan on Becoming Pregnant…….. | □ | □ |

## WEIGHT HISTORY (Answer to the best of your ability)

What was your weight:

In high school_____ After College_____ When you got married_____

After Pregnancy(ies)_____ 30's_____ 40's_____ 50's_____ 60's_____ 70's_____

## HOSPITALIZATIONS (Please list those operations or serious illnesses that you have had which required hospitalization. If you have had more than five, check the box. □

| Month/Year | Illness or Operation | Attending Physician's Name | Complications Yes | Complications No |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| **MEDICATIONS NOW TAKING:** Are you now taking any of the following: | Yes | No |
|---|---|---|
| 1. Antibiotics…… | □ | □ |
| 2. Penicillin…….. | □ | □ |
| 3. Sulfa Drugs……. | □ | □ |
| 4. Aspirin…….…… | □ | □ |
| 5. Codeine/Demerol/Other Pain medicine……. | □ | □ |
| 6. Sedatives/tranquilizers…….……. | □ | □ |
| 7. Birth control pills…….……... | □ | □ |
| 8. Estrogens…….…..... | □ | □ |
| 9. Other hormones…….…… | □ | □ |
| 10. Blood pressure or heart medicines…….. | □ | □ |
| 11. Thyroid medication…… | □ | □ |
| 12. Other medicines/vitamins……. | □ | □ |
| 13. Are you allergic to or do you react poorly to any medicines? ..... | □ | □ |
| 14. Are you a habitual user of any medications or drugs? ..... | □ | □ |
| 15. Are you using prescription or over the counter diuretics? ……..... | □ | □ |
| 16. Do you take vitamin or mineral supplements? ..... | □ | □ |
| 17. Do you take herbal supplements? ..... | □ | □ |
| 18. Do you use topical creams, cleansers or moisturizers that contain hormones or oils? ……. | □ | □ |

PLEASE LIST MEDICATIONS/SUPPLEMENTS YOU ARE NOW TAKING

1. _____ 4._____
2. _____ 5. _____
3. _____ 6. _____

OCCUPATION_____

EXERCISE (Frequency and Type)_____

_____