

___/___/20___; Last Name: _____ First Name: _____ Age: _____

MEDICAL HISTORY

PAST MEDICAL HISTORY (SIGNIFICANT CHRONIC MEDICAL PROBLEMS):

PAST SURGICAL HISTORY:

MEDICATION ALLERGIES:

| | | | | | |
|---|--|---|--|---|--|
| FAMILY HISTORY: | | Hyperlipidemia <input type="checkbox"/> | | Asthma <input type="checkbox"/> | |
| Coronary Artery Dis. before age 50 <input type="checkbox"/> | | Thyroid Disorder <input type="checkbox"/> | | Chronic Obstructive Pulmonary Dis. <input type="checkbox"/> | |
| | | Diabetes <input type="checkbox"/> | | Blood Disorders <input type="checkbox"/> | |
| Congestive Heart Failure <input type="checkbox"/> | | | | Rheumatoid Arthritis <input type="checkbox"/> | |
| Hypertension <input type="checkbox"/> | | Cancer <input type="checkbox"/> | | Neuropsychiatric Dis. <input type="checkbox"/> | |
| Stroke <input type="checkbox"/> | | | | Gastrointestinal Dis. <input type="checkbox"/> | |
| Peripheral Artery Dis. <input type="checkbox"/> | | Kidney Diseases <input type="checkbox"/> | | | |

| | | | |
|------------------------|--|----------------------------------|---------------------------------------|
| SOCIAL HISTORY: | Alcohol <input type="checkbox"/> | Smoking <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> |
| | Illicit Drugs <input type="checkbox"/> | | |

HISTORY OF MOST RECENT SCREENING PROCEDURES:

Colonoscopy Year _____ Results: _____

Upper Endoscopy Year _____ Results: _____

Mammogram Year _____ Results: _____

Pap Smear Year _____ Results: _____

ADDITIONAL INFORMATION:
