PATIENT HISTORY

Name______________
Date______________
Birthdate

Family History

Age if alive or Age at death	Cause of death if deceased	Medical Problems (check all that apply) Cancer (what kind)	Heart Attack or Angina	Heart Failure	Emphysema	High Blood Pressure	Diabetes	Rheumatoid Arthritis	Mental Illness	Alcoholism	Seizure or Epilepsy	Kidney Disease	Bleeding Disorder	Glaucoma	Asthma	Stroke
Father																
Mother																
Bro/Sis																
Bro/Sis																
Bro/Sis																
Bro/Sis																
Bro/Sis																
Child																
Child																
Child																
Other(who?)																
Other(who?)																
Other(who?)																
Other(who?)																

Medicines

Name	Strength	How Often

Medical Illnesses (e.g. diabetes, high blood pressure, kidney stones, etc.)

____

Major Surgeriesand Injuries (and year or age)(including tonsillectomy, vasectomy, tubal ligation,cesareans)

____

When was your last... Complete Physical?__________ Sigmoidoscopy/ colonoscopy (if ever)?__________

Eye exam?__________ Dental exam?__________ Tetanus shot?__________ EKG?__________

Stress test (if ever)?__________ Pap Smear (if Female)?__________ Mammogram(if Female)?__________

Do you smoke?(if so, how much)?__________ **Drink alcohol?**__________

What is your occupation?__________ **If retired what year?**__________

Total Number of Pregnancies, if female(including miscarriages, stillbirths and terminations):__________

Names and ages of children at home:__________

Do you have a living will?__________ **If not would you like to see one?**