Medical History and Assessment Form

Date: _____ Name (Last, First, Middle) _____ DOB _____

Phone Number: _____ Date Last Seen: _____ Date of Last Physical: _____

Date of Last Tetanus: _____ Flu Vaccine: _____Pneumonia Vaccine: _____ Hep. B Vaccine: _____

Date of Last Mammogram: _____ Pap: _____ Cancer Screening: _____

Date of Last Hemoccult: _____ PSA/DRE (Prostate): _____ Are you allergic to Latex? _____

Medication Allergies: _____

Past Medical History (Check If You Ever Had)

	Asthma		Diabetes		Heart Attack		Seizures
	Anemia		Emphysema		High Blood Pressure		Stroke
	Blood Clots		GERD		High Cholesterol		Thyroid Disease
	Congestive Heart Failure		Glaucoma		Kidney Stones		Ulcers
	Other						

Current Medications	Dose	Frequency	Surgeries (List Type and Date)
1.			**1.**
2.			**2.**
3.			**3.**
4.			**4.**
5.			**5.**
6.			**6.**
7.			**7.**
8.			**8.**
9.			**9.**
10.			**10.**

Family History	Father	Mother	Sibling	Other	What Kind
Diabetes					
Cancer					
Heart Disease					
Death Before Age 50					
High Cholesterol					

Tobacco: ☐ **Never** **Quit in (yr) ____** **Cigs/Packs Per Day: _____** ☐ **Cigars** ☐ **Chew or Snuff**
(Please Circle Above) **(Please Circle Above)**

Alcohol: ☐ **Never** **Drinks Per Day: ____** **Week: _____** **Month:_____** **Illicit Drugs:** ☐**Yes** ☐ **No**

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and its my responsibility to inform this office of any chances in my medical status.

_____ _____

Signature of Patient or Legal Guardian **Date**