Medical History

ArborPlaceFamilyMedicine

Full Name:_____ Age: _____ Birthdate: ____/____/____

Address: _____ Sex: ▫ Male ▫ Female

_____ Home phone:_____

Occupation:_____ Work phone:_____

Phone:_____ Emergency Contact: _____

Marital Status: ▫ Married ▫ Divorced ▫ Widowed ▫ Separated

If married, spouse's name: _____

Children's names and ages: _____

Allergies

Are you allergic to any medications, x-ray dyes, or other substances? ▫Yes ▫No
If yes, please list (name and type of reaction): _____
_____

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

▫Heart disease / Murmur / Angina ▫High cholesterol
▫High blood pressure
▫Low blood pressure
▫Heartburn (reflux)
▫Anemia or blood problems ▫Swollen ankles
▫Shortness of breathe
▫Asthma
▫Lung problems / cough
▫Sinus problems
▫Seasonal allergies
▫Tonsillitis
▫Ear problems
▫Eye disorder / Glaucoma ▫Seizures
▫Stroke
▫Headaches / Migraines ▫Neurological problems
▫Depression / Anxiety
▫Psychiatric care
▫Diabetes
▫Kidney / Bladder problems
▫Liver problems / Hepatitis
▫Arthritis
▫Cancer
▫Ulcers/colitis
▫Thyroid problems
▫Please describe any current or past medical treatment not listed above

_____
_____
_____

Please list your past surgeries:

_____
_____

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name: _____ _____ _____ _____

Dose: _____ _____ _____ _____

Females: Gynecological History

How many times have you been pregnant? _____

Have you had an abnormal Pap Smear? ▫Yes ▫No
Diagnosis: _____Follow up: _____

Have you had a sexually transmitted disease? ▫Yes ▫No
Diagnosis: _____

Date of last mammogram: _____
Mammogram results: _____

Have you ever had a breast biopsy? ▫Yes ▫No
Diagnosis: _____

Date of last Pap Smear:_____

Family History

Has any member of your family (including children and parents) had any of the following illnesses:

Illness:	**Which family member?**
Anemia or Blood disease	_____
Cancer	_____
Diabetes	_____
Glaucoma	_____
Heart disease	_____
High blood pressure	_____
HIV disease / AIDS	_____
Mental Illness / Depression / Stroke	_____
Other serious illness	_____

Social and Preventive History

Do you currently smoke or chew tobacco? ▫Yes ▫No
If no, have you in the past? ▫Yes ▫No
How many packs per day? _____

Do you drink alcohol, beer, or wine? ▫Yes ▫No
If no, have you in the past? ▫Yes ▫No
How many drinks per week? _____

Do you currently drink coffee and/or tea? □Yes □No
If yes, how many cups per day? _____

Do you exercise daily/weekly? □Yes □No

Do you use a seatbelt while driving? □Yes □No

Do you wear a helmet while riding a bike? □Yes □No

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature_____

Date _____