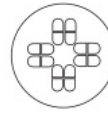


Medical History



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:

- Anemia or Blood disease
- Cancer
- Diabetes
- Glaucoma
- Heart disease
- High blood pressure
- HIV disease / AIDS
- Mental Illness / Depression / Stroke
- Other serious illness

Which family member?

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 _____