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Medical History

Name: ______________________ Date of Birth: ____________

What is the reason for coming to see the doctor today: ____________________

Are you allergic to any medicines or foods, if so please list below:

____

____

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Please List All Medications you take on a daily basis (Prescription and Over the Counter):

Name of Medicine	Dosage	Times Taken a Day

Are you currently a Tobacco Smoker? --Yes --No --Former Smoker

Are you a Coffee Drinker? --Daily --Regularly --Socially --Occasionally --None

Are you a Tea Drinker? --Daily --Regularly --Socially --Occasionally --None

Do you participate in Recreational Street Drug Usage? --Yes –No ---If yes, what do you use and how much per day: ____________

How often do you consume more than 4 Alcoholic Beverages in 1 sitting? ________________

Consume Alcoholic Beverages? --Daily --Regularly --Socially --Occasionally -None

Have you lost more than 15lbs in the past 3 months unintentionally? --Yes --No

Please List Your Past Medical History Below: (example: What Medical Conditions have you been treated for in the past? What conditions do you take medications for?)

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Please List Your Past Surgical History Below: (**Example**: Do you still have your Appendix, Gall Bladder, Uterus, Tonsils and/or Hernias?)

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Please Check All the SYMPTOMS that Apply to You and Your Visit Here Today:

---Asthma ---Abdominal Pain ---Abnormal Blood Test ---Abdominal Distention/Swelling

---Anal/Rectal Pain ---Anemia --- Change in Bowel Habits ---Chest Pain/Pressure

---Cirrhosis of Liver ---Constipation ---Diarrhea ---Diabetes ---Dyspepsia/Indigestion

---Dysphagia/Trouble Swallowing ---Fecal Impaction ---Gastro Reflux ---G.I. Bleed

---Heartburn ---Heart Murmur --- Blood in Stool ---Hemorrhoids ---Hepatitis

---Hiatal Hernia ---Hypertension ---Incontinence ---Nausea ---Rectal Bleeding

---Shortness of Breath ---Weight Loss ---Vomiting

Do you have any Family History of Colon Cancer: --Yes --No

If yes, who was it: ________________________________

Do you have any Family History of Gastric/Stomach Cancer? --Yes --No

If yes, who was it: ________________________________

Do you have and Family History of Breast Cancer? : --Yes --No

If yes, who was it: ________________________________

Family History

Father: -Living -Deceased Major Illness/Cause of Death _______________

Mother: -Living -Deceased Major Illness/Cause of Death _______________

Sister: -Living -Deceased Major Illness/Cause of Death _______________

Brother: -Living -Deceased Major Illness/Cause of Death _______________

Females Only:

Date of Your Last Menstrual Period: ____________________

Have you had a Hysterectomy: ______________________

Are you Postmenopausal: __________________________

Date of Last PAP Smear:__________

Date of Last Mammogram:_________

Date of Last DEXA SCAN:_________

Have you had any Labs (blood work) or Studies (ie: CT, MRI, X-Ray, Ultrasound) within the past 6 months? (If YES then where were tests performed?)

Date of Last Flu Shot:___________

Date of Last Pneumonia Shot:______