

# PATIENT MEDICAL HISTORY

## CURRENT MEDICATIONS AND DRUG ALLERGIES

What medications are you currently taking? Include doses.

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Drug allergies:

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## SOCIAL HISTORY

Do you drink caffeinated beverages?  yes  no

Do you consume alcohol?  yes  no

If yes, what type of alcohol? \_\_\_\_\_

If yes, how much and how often? \_\_\_\_\_

Do you smoke?  yes  no

If yes, how many years? \_\_\_\_\_ & packs per day? \_\_\_\_\_

If you stopped smoking, give the date. \_\_\_\_\_

What do you do for exercise? \_\_\_\_\_

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Marital Status

married  single  divorced

widowed  separated

Occupation \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_

List the individuals in your household for whom you are the caregiver.

(relationship & age) \_\_\_\_\_

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## SURGICAL HISTORY & HOSPITALIZATIONS

List date and type of surgery.

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List date and reason for hospitalization.

(exclude surgery) \_\_\_\_\_

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## FAMILY MEDICAL HISTORY

Relation Living/Deceased Cause of Death

Father  L  D \_\_\_\_\_

Mother  L  D \_\_\_\_\_

sibling(s): (Circle brother or sister)  
brother/sister  L  D \_\_\_\_\_

brother/sister  L  D \_\_\_\_\_

brother/sister  L  D \_\_\_\_\_

brother/sister  L  D \_\_\_\_\_

Has any immediate blood relative ever had:

(father, mother, sister, brother) If yes, who?

anemia  yes  no \_\_\_\_\_

bleeding disorder  yes  no \_\_\_\_\_

cancer  yes  no \_\_\_\_\_

diabetes  yes  no \_\_\_\_\_

epilepsy  yes  no \_\_\_\_\_

heart disease  yes  no \_\_\_\_\_

hypertension  yes  no \_\_\_\_\_

kidney disease  yes  no \_\_\_\_\_

mental illness  yes  no \_\_\_\_\_

stroke  yes  no \_\_\_\_\_

thyroid disease  yes  no \_\_\_\_\_

tuberculosis  yes  no \_\_\_\_\_

\* If yes, at what age did he/she have heart attack? \_\_\_\_\_