PATIENT HISTORY RECORD

Your name _____ Birth date _____

MEDICINES YOU ARE TAKING List medicines and dosages, birth control pills, or vitamins you take with or without a prescription and bring your current medication containers along with you for your appointment.

_____ _____ _____
_____ _____ _____
_____ _____ _____

DRUG and/or OTHER ALLERGIES List those to which you are allergic:

_____ _____ _____
_____ _____ _____

HOSPITALIZATIONS List serious illnesses and injuries or operations and approximate year. EXCLUDE NORMAL PREGNANCIES.

Year	Serious illness, injury or operation	Name of hospital	City and State
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IMMUNIZATIONS Check those that you have had. Note most recent year received.

☐ Pneumonia _____ ☐ Polio _____ ☐ Flu _____ ☐ Tetanus _____
☐ Rubella _____ ☐ Others _____ _____ _____ _____
_____ _____ _____ _____

OUR FAMILY'S HEALTH

	First Name	Year of birth	Health is: Good	Poor	Died at	Age	Cause of death
Father	_____	_____	☐	☐	☐	_____	_____
Mother	_____	_____	☐	☐	☐	_____	_____
Brothers and Sisters	_____	_____	☐	☐	☐	_____	_____
	_____	_____	☐	☐	☐	_____	_____
	_____	_____	☐	☐	☐	_____	_____
	_____	_____	☐	☐	☐	_____	_____
	_____	_____	☐	☐	☐	_____	_____
	_____	_____	☐	☐	☐	_____	_____
	_____	_____	☐	☐	☐	_____	_____
Spouse	_____	_____	☐	☐	☐	_____	_____
Children	_____	_____	☐	☐	☐	_____	_____
	_____	_____	☐	☐	☐	_____	_____
	_____	_____	☐	☐	☐	_____	_____
	_____	_____	☐	☐	☐	_____	_____

ILLNESSES Check where you or members of your family have had the following illnesses or problems:

You	Your family	
☐	☐	Alcoholism
☐	☐	Anemia
☐	☐	Asthma
☐	☐	Cancer, tumor
☐	☐	Diabetes
☐	☐	Drug abuse
☐	☐	Depression
☐	☐	Eczema, hives, rashes
☐	☐	Epilepsy
☐		Eye problems
☐	☐	Glaucoma
☐	☐	Heart disease
☐	☐	High blood pressure
☐	☐	HIV
☐	☐	Kidney/bladder problems
☐	☐	Liver disease, hepatitis, yellow jaundice
☐	☐	Lung disease, tuberculosis
☐		Mumps, measles, chicken pox
☐	☐	Nervous breakdown/mental illness
☐	☐	Phlebitis
☐	☐	Rheumatic fever
☐		Rubella, German measles
☐	☐	Sexually transmitted disease
☐	☐	Stroke
☐	☐	Suicide attempt
☐	☐	Thyroid disease
☐	☐	Ulcer in stomach/duodenum
☐	☐	Uncontrolled bleeding
		Other illnesses:
☐	☐	_____
☐	☐	_____

PREGNANCY HISTORY

Enter the number of:

Times pregnant ..... _____
Premature births ..... _____
Miscarriages ..... _____
Abortion ..... _____
Live births ..... _____
Living children ..... _____

TOBACCO USE:

Smoke Y/N _____packs _____years
Chew Y/N _____years

ALCOHOL USE:

☐Yes Amount/week _____
☐No
Ever abuse alcohol? Y/N

DRUG USE:

☐Yes
☐No