

## Comprehensive Medical History

This important information is confidential. No one other than your healthcare provider will have access or knowledge of this information without your express written consent. Thank you very much for taking the time to fill out this lengthy form. Completion of this history allows us to provide you the most complete medical care possible.

**Name:** \_\_\_\_\_ **Birthdate** \_\_\_\_\_

Date of your last complete physical exam? \_\_\_\_\_ Cholesterol test? \_\_\_\_\_

**Women:** Date of last mammogram? \_\_\_\_\_ Pap smear? \_\_\_\_\_

Date of last period? \_\_\_\_\_ or Age at menopause? \_\_\_\_\_

**Men:** Date of last PSA? \_\_\_\_\_ Rectal/prostate exam? \_\_\_\_\_

**Allergies:** Please list any drug, food, contact or environmental substances to which you have had an allergic or bad reaction:

\_\_\_\_\_

**Medications:** Please list any prescription medications, over the counter medications, vitamins, herbal or nutritional supplements that you are now taking:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Social History:

Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Do you exercise? \_\_\_\_\_ What type? \_\_\_\_\_ How often? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How many per day? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you use other forms of tobacco? \_\_\_\_\_ What form? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How often/how much? \_\_\_\_\_

### Family History:

Check all that apply to immediate family (Mother, Father, Sisters, Brothers)

Anemia \_\_\_\_\_ Asthma \_\_\_\_\_ Obesity \_\_\_\_\_ Cancer \_\_\_\_\_

Diabetes \_\_\_\_\_ Stroke \_\_\_\_\_ Epilepsy \_\_\_\_\_ Glaucoma \_\_\_\_\_

Leukemia \_\_\_\_\_ Depression \_\_\_\_\_ Heart disease \_\_\_\_\_ High cholesterol \_\_\_\_\_

Kidney disease \_\_\_\_\_ Thyroid disease \_\_\_\_\_ High blood pressure \_\_\_\_\_ Lung disease \_\_\_\_\_

**Patient's Name** \_\_\_\_\_

**Please circle all conditions you currently have or have had within the past year:**

Diabetes

High Blood Pressure

Cholesterol Problems

Depression

Anxiety

Weight Change

Thyroid Problems

Eye Problems

Ear Problems

Nose Problems

Throat Problems

Neck/Back/Joint/Muscle Problems

Heart Problems

Lung Problems

Chest Pain

Shortness of Breath

Abdominal Pain

Arthritis

Sexual Problems

Skin Problems

Any other problem you feel is important to your health:

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