

PATIENT MEDICAL HISTORY AND PHYSICAL

Patient Name: _____

Marital Status:

Single

Divorced

Married

Widowed

Date of last complete examination: _____

Education (circle highest grade completed)

High School: 6 7 8 9 10 11 12

College: 1 2 3 4 or more

Occupation: _____ How long? _____ Previous Occupations:

Doctor's Notes

Are you legally disabled? _____ Describe _____

Habits

Do you use tobacco now? _____ In the past? _____ Type and daily amount _____

How long? _____

Do you use alcohol now? _____ In the past? _____ Type and daily amount _____

How long? _____

Do you use other recreational drugs? _____

Do you exercise regularly? _____ Please Describe: _____

Do you follow any special diet (e.g. low cholesterol)? _____ Type _____

Date of Last period: _____ Are they regular? _____

Any problems? _____

Family History

	Living?	Age or age at death	Describe any health problems or cause of death
Father	Yes / No		
Mother	Yes / No		
Spouse	Yes / No		

Age of Brothers/ Sisters _____ List Health Problems _____

Ages of Children _____ List Health Problems _____

Please circle illnesses which have occurred in your blood relatives

Diabetes	Heart Attacks	Nervous Illness	Breast Cancer
Stroke	High Blood Pressure	Thyroid Problems	Asthma / Hay Fever

Allergies (to medications):

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