GENERAL MEDICAL INFORMATION

NAME_____
Age_____ Height_____ft_____in. Weight_____lbs
Current Medical problem/reason for visit_____
Present medications:_____

Allergies_____
Other Physicians currently treating you_____
Previous hospitalizations/surgeries:_____

Do you smoke? ___ Yes ____No No. of years_____ Amount_____
Interested in stopping?_____
Do you regularly drink alcohol? ___Yes ____No Amount_____
Females only: Pregnant?_____Planning pregnancy?_____Nursing a child?_____

PAST MEDICAL HISTORY

___Arthritis	___Asthma	___Chest pain	___Cancer
___Cataracts	___Dizzy spells	___Depression	___Diabetes
___Hepatitis	___Glaucoma	___Hypertension	___Digestive problems
___Blood in stool	___Stroke	___Heart attack	___Headaches
___Memory loss	___Skin disorders	___Kidney disease	___Hemorrhoids
___Difficulty hearing	___Failing vision	___Shortness of breath	___Ulcers
___Sexual dysfunction	___Back pain	___Chronic fatigue	___Frequent infections
___Pneumonia	___Thyroid disease	___Osteoporosis	___Seizures

Other_____

FAMILY MEDICAL HISTORY

	Mother	Father	Mother's parents	Father's parents	Children	Siblings
Alcoholism						
Hypertension						
Epilepsy						
Cancer						
Stroke						
Diabetes						
Heart attack						
Asthma						
Mental illness						
Migraines						