MEDICAL HISTORY / MEDICATION SHEET

Patient Name: _____ **DOB:** _____ **Date of Visit:** _____

Please list all medications, vitamins, herbal supplements and any other over-the-counter medication you are taking with the strength and directions of each. (PLEASE LIST EVERY PILL YOU TAKE)

MEDICATIONS / VITAMINS	STRENGTH (Ex. 50 mg)	DIRECTIONS (Times a day)	MEDICATIONS / VITAMINS	STRENGTH (Ex. 50 mg)	DIRECTIONS (Times a day)

Please list all Medication Allergies: _____

Past Medical History: Please summarize your medical history. Indicate if you have had diabetes, hypertension, high cholesterol, cancer, thyroid, pulmonary, neurologic disease, kidney disease, gastroenterologic disease, etc. Note the approximate onset in months/years.

_____

_____

_____

_____

Family History: Please summarize illnesses that your family members (parents, brothers/sisters, etc.) have or have had. Include age at time of onset of illness and age at time of death (ex. Heart attack at 56 and died of heart failure at 60. He also had diabetes and high blood pressure. He was a heavy smoker)

Mother: _____

Father: _____

Brothers/Sisters: _____

Other: _____

_____

Social History:

Do you or have you ever smoked or used any other tobacco products? Yes No How much per day/week? _____

Do you consume alcohol? Yes No How much per day/week? _____

Past Surgical History: Please indicate type of surgery, date and why it was done (ex. Hysterectomy at 45 for fibroids)

_____

_____

How did you hear about our practice? _____

Primary Care Physician (address and phone number): _____