

Pertinent Medical History

Obtaining a complete and accurate history prior to visiting the doctor helps our physician to make a more appropriate diagnosis and treatment plan. Every piece of information is relevant and assists us in giving you better quality care, which saves time for both of us. Please fill out the form completely and accurately. Thank you.

First Name _____ Today's date _____

Last Name _____ DOB _____

Name of your referring or primary care physician? _____

Your height _____ Your weight _____ lbs

REASON FOR THE VISIT TODAY

Please explain what brought you in today? How long has this persisted?

PAST MEDICAL HISTORY

Please list your known medical disease and duration

CURRENT MEDICATION, DOSAGE & FREQUENCY:

PAST SURGICAL HISTORY AND MAJOR HEALTH EVENTS:

Please list any previous surgery or any other major medical event with its date

HABITS:

Do you smoke? NO YES, what, how many for how many years? _____

Do you drink alcohol? NO YES, what, how much and how many years? _____

Any use of illicit drugs? NO YES, what and for how many years using? _____

ALLERGIES:

Are you allergic to any drugs or food? No YES, what are you allergic to and what type of reaction you showed?

PREVENTIVE CARE:

When was your last physical? _____

When was your last blood test? _____

Have you had any other preventive care such as vaccines, screening colonoscopy? PSA check?
Etc. Please list it below.

FAMILY HISTORY:

Mother's age and health history? _____

Father's age and health history? _____

Grandmother's history? _____

Grandfather's history? _____

Sibling's medical history? _____

FOR FEMALE PATIENTS ONLY:

Menstruation regular irregular painful heavy bleeding

Sexually active _____ Type of contraceptive using _____

of pregnancies _____ # of children _____

Date of last pap smear _____

Date of last mammogram _____

I confirm that the above information is accurate and complete.

Patient signature X _____