Past Medical History

Instructions: Please check all that apply

	Yes	No		Yes	No
Allergies (excluding medications)	☐	☐	Gout	☐	☐
Asthma	☐	☐	Heart murmur (as an adult)	☐	☐
Anemia (Type: ______________)	☐	☐	Heart attack	☐	☐
Blood clotting problems	☐	☐	High blood pressure	☐	☐
Cancer	☐	☐	Kidney infection	☐	☐
Chest pain	☐	☐	Kidney stones	☐	☐
Colon/bowel problems	☐	☐	Migraine headaches	☐	☐
Depression	☐	☐	Rheumatic fever	☐	☐
Diabetes	☐	☐	Seizures	☐	☐
Ear/nose/throat	☐	☐	Stroke	☐	☐
Emphysema	☐	☐	Skin disease	☐	☐
Gall Stones	☐	☐	Thyroid	☐	☐
MEN: Prostate problems	☐	☐	**WOMEN:** GYN problems	☐	☐

Smoking history: ☐ **Yes** ☐ **No** ____________________________

Alcohol history: ☐ **Yes** ☐ **No** ____________________________

Recreational drugs: ☐ **Yes** ☐ **No** ____________________________

Family History:

	Deceased?	Cause of death
Father		
Mother		
Sister (s)		
Brother (s)		

Past Surgical History:

	Yes?	Date / Comments / Complications
Tonsillectomy	☐	
Appendectomy	☐	
Thyroid	☐	
Gall bladder	☐	
Heart – bypass	☐	
Any joint?	☐	
Any other?	☐	

Comments / Additional Information:

____

____

____

____

____

____

For office use only:

Addendum

Signature: ____________________ **Signature:** ____________________ **Signature:** ____________________ **Signature:** ____________________

Date: ____________________ **Date:** ____________________ **Date:** ____________________ **Date:** ____________________