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MEDICAL HISTORY SHEET

Name: _____ Date: _____

Birth Date: _____

Medical History (please check all that apply):

____Allergies/Hay Fever	____Depression	____Hepatitis
____Anemia	____Diabetes	____High Blood Pressure
____Asthma/Breathing Problems	____Diverticulitis/Diverticulosis	____H. Pylori Disease
____Bleeding Disorder	____Dizziness/Fainting	____Peripheral Vascular Disease
____Bowel Irregularity	____Fecal Incontinence	____Prostate Disease
____Breast Cyst(s)	____GERD	____Shortness of Breath
____Breast Lump	____Headache	____Stroke
____Cancer, Type: _____	____Heart Disease	____Ulcer, Location: _____
____Chest Pain	____Heart Palpitations	____Venereal Disease
____Blood in stool	____Arthritis	____Kidney Disease

Other (Not Listed Above): _____

Why are you seeing the Doctor today? _____

Any Recent Hospitalizations? _____

Medications/Vitamins/Supplements:

_____
_____
_____
_____
_____
_____
_____

Prior Surgeries and Date if Known

_____
_____
_____
_____

Smoking: Y N Quit If Quit, When: _____

If yes, Packs per Day: ____ How Long: _____

Alcohol: Y N If yes: # drinks per week_____

Recreational drugs: Y N If yes: What:_____

ALLERGIES: _____

Family History (please check all that apply):

	Father	Mother	Brothers	Sisters
Bleeding	_____	_____	_____	_____
Cancer, breast	_____	_____	_____	_____
Cancer, colon	_____	_____	_____	_____
Other cancer_____	_____	_____	_____	_____
Inflammatory bowel disease	_____	_____	_____	_____
Heart disease or heart attack	_____	_____	_____	_____
Problems with anesthesia	_____	_____	_____	_____