



Patient Medical History

Patient Name: _____	Date: _____
Age: _____	

Name of Family Doctor: _____

Immunizations: Flu Pneumonia Tetanus **Medical Allergies:** _____

Current Medications and Doses:

Notes:

Past Medical History (Have you ever had?)

- | | |
|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer |

Past Surgical History:

Family History (circle those that apply):

- Heart Disease Cancer Stroke Diabetes
- Blood Clots Lung Disease

Have you traveled outside Washington in the past two years? Yes No

Have you ever been exposed to someone with tuberculosis? Yes No

Do you have pets? Yes No

Marital Status: Single Married Widowed Divorced **Children:** Yes No

Retired: Yes No **Occupation History:** _____

Leisure Activities: _____

Do You Exercise? Yes No **If yes, what and how much?** _____

Have You Ever SMOKED? Yes No **If yes, how much?** _____ **or When did you quit?** _____

Do you drink ALCOHOL? Yes No **If yes, how much and how often?** _____

Do you use any recreational drugs? Yes No

PATIENT SIGNATURE _____