Patient Medical History

Name: _____ **Birthday:** _____

Current Pharmacy: _____ **Location:** _____

Medication Name	Dose	Times Taken Per Day

Medication Allergies & Reactions

Current/Previous Medical Conditions

Surgery/Hospitalization

MO/YR	Procedure/Reason

Continue on back →

Patient Medical History

Family Medical History

Mother: Alive / Deceased Medical Conditions:_____

Father: Alive / Deceased Medical Conditions:_____

Other family medical conditions: _____

_____

Last Colon Cancer Screening (MO/YR):_____

Family Hx of Colon Cancer? **YES** **NO** Relationship:_____

Females Only

First Day of Your Last Period: _____

Menopause: **YES** **NO** Hysterectomy: **YES** **NO** If yes, **partial or complete**

Last Pap Smear (MO/YR): _____ Last Mammogram (MO/YR):_____

Family Hx of Breast Cancer: **YES** **NO** Relationship:_____

Males Only

Last Prostate Cancer Screening (MO/YR):_____

Social History

Are you now or have you ever been a smoker, including vapes?

Never **Former** **Current**

Have you consumed alcohol in the past year? **YES** **NO** How often:_____

Any current or past drug abuse? **YES** **NO**

Current or Former Specialists

Provider/Office Name	Specialty	Phone Number

Any other information you would like your provider to know?_____

_____

_____