



Medical History

Patient Name: _____ Date: _____

Reason for visit: _____

List any illness, injuries or surgeries:

List all current medications, strengths and frequency:

Medication

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Are you allergic to any medication? Y or N (please list below)

Date of last Physical Exam: _____

(Women only)

PAP Smear: _____ Menstrual Period: _____ Mammogram: _____

Have you ever had: (please circle all that apply)

High Blood Pressure	Kidney Problems	Neurologic disorder	Lung Problem
Diabetes	High Cholesterol	Thyroid Problem	Arthritis
Cancer	Heart Problems/ Murrur	Ulcers	HIV Infection
Pneumonia	Blood in Stool / Urine	Skin Test for Tuberculosis	

Health Habits: Current Smoker: Y or N
Cigarettes per day: _____
Years smoking: _____

Previous Smoker: Y or N
Cigarettes per day: _____
Years smoking: _____

Do you drink alcohol? Y or N if so, how much?

Do you exercise regularly? Y or N if so, how much?

Diet History:

Present Diet: _____ Previous Diet Plans: _____

Have you taken appetite suppressants in the past? Y or N

Any adverse effects? _____

Most you have ever weighed? _____ At what weight would you be happy? _____

Signature: _____ Date: _____