PATIENT'S MEDICAL HISTORY FORM

DRS. FARR, WAMPLER, DOUGHERTY, BROWN, ZUBOWICZ & GORDON

Patient's Name:_____Date:_____

What is the reason for your visit today?_____

_____

Please List all of your Medical Problems (current & old)_____

_____

_____

Please List all of your Previous Surgeries_____

_____

Do any of these Medical Problems apply to you? Please Check box to the right of those that do.

Heart Disease		Diabetes		Depression		Diarrhea	
Chest Pain		Thyroid Disease		Stroke		Constipation	
Heart Murmer		Arthritis		Nervous Disorder		Stomach Ulcers	
High Blood Pressure		Kidney Stones		Back Pain		Heartburn	
Shortness of Breath		Blood in your Urine		Blood Transfusion		Hernia Repairs	
Asthma/Emphysema		Frequent Urination		HIV or Hepatitis		CANCER: list type(s)	
Blood with Coughing		Pain with Urination		Bleeding Tendency			
Anesthetic Reaction				MRSA			

Please list **ALL** the **MEDICATIONS** you are presently taking._____

_____

_____

Are you **ALLERGIC** to any **MEDICATIONS**? (Please list)_____

_____

SOCIAL HISTORY:

Do you Smoke? Yes_____ No_____

If Yes, how much a day?_____ If you stopped, When?_____

Do you Drink Alcohol? Yes_____ No_____

If Yes, how much?_____ If you stopped, When?_____

MARITAL STATUS: Single_____Married_____Separated_____Divorced_____

Widowed_____ How Many Children?_____

FAMILY MEDICAL HISTORY:

Please list any close relatives that have a history of the following diseases: Heart Disease, Stroke, Diabetes, Cancer? If there are other diseases that run in your family, please list.

_____

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services that I may need.

X_____

Signature of Patient or Guardian Date

Office use only:
Date: