# BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE

## MEDICAL HISTORY

Please fill out completely and accurately. This becomes part of your permanent record and will help us to make recommendations regarding your care.

PATIENT NAME: _____ DATE OF BIRTH:_____

**PAST MEDICAL HISTORY:**

| Have you a history of: | Check if yes |
|---|---|
| ALLERGIES / HAY FEVER | ❑ |
| ANEMIA | ❑ |
| ARTHRITIS | ❑ |
| ASTHMA / EMPHYSEMA / COPD | ❑ |
| BLOOD CLOT | ❑ |
| CANCER | ❑ |
| CHEST PAINS / ANGINA | ❑ |
| CHOLESTEROL PROBLEMS | ❑ |
| DEPRESSION OR ANXIETY | ❑ |
| DIABETES | ❑ |
| HEADACHES / MIGRAINES | ❑ |
| HIGH BLOOD PRESSURE | ❑ |
| HIV / AIDS | ❑ |
| INTESTINAL DISORDERS | ❑ |
| MITRAL VALVE PROLAPSE OR RHEUMATIC FEVER | ❑ |
| OTHER HEART PROBLEMS | ❑ |
| SEIZURES | ❑ |
| SLEEP DISORDERS | ❑ |
| STROKE / TIA | ❑ |
| THYROID PROBLEMS | ❑ |
| ULCERS | ❑ |

DRUG USE : _____

TOBACCO USE: _____
(PACKS PER DAY & # OF YEARS)

ALCOHOL USE: _____
(AVERAGE AMOUNT OR FREQUENCY)

EXERCISE: _____ HOBBIES: _____

EDUCATION COMPLETED: _____

# of Pregnancies: _____ # of Deliveries: _____ # of Miscarriages:_____

Frequency of Periods: _____Last Menstrual Period_____Last PAP _____

Any Foreign Travel_____

## FAMILY HISTORY:

| | √ | Which family member? Maternal or Paternal |
|---|---|---|
| DIABETES | | |
| HIGH BLOOD PRESSURE | | |
| HEART ATTACK | | |
| HIGH CHOLESTEROL | | |
| STROKE | | |
| ASTHMA | | |
| SUICIDE/DEPRESSION | | |
| ALCOHOLISM | | |
| CANCER (& WHAT TYPES) | | |
| OTHER | | |

**Current Medications & doses:**_____

_____

_____

**Allergies to Medicine and your reaction:** _____

_____

**Spouse/Children/Parents' Names & Ages:**_____

_____

**Previous Illness/Injuries/Hospitalizations/Surgeries including year:**_____

_____

_____

_____

**Last Tetanus Booster:**_____ **Occupation & Employer:**_____

**The above information is true and complete to the best of my knowledge.**

**Signature**_____ **Today's Date:**_____

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