Patient Medical History Form

List medications you are currently taking: (Include birth control pills and non-prescriptive items such as vitamins, aspirin, herbs etc.)

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Often							
3.		Dose	How Many	Tablets o	r Capsules		How
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Past Surgical History: No Yes (Please cir	cle all that apply and wri	te in year)				
Carpel tunnel (Right, Left, Bilateral)	Hip Replacem	ent (Right, Left, Bilatera	al)			
Appendix Removed	Joint Replacement Kidney Biopsy (Right, Left)					
Bladder Removed						
Mastectomy (Right, Left, Bilateral)	Kidney Remov	ed (Right, Left)				
Lumpectomy (Right, Left, Bilateral)						
Breast Biopsy (Right, Left, Bilateral)	Kidı	ney Transplant				
Breast Reduction		state Removed				
Breast Implants		sy				
Colon Cancer Resection	TURP					
Gallbladder Removed	Skin Biopsy (B	Basal cell, Squamous cell	, Melanoma)			
Coronary Artery Bypass	Spleen Remov	/ed				
Heart Transplant	Test	ticles Removed (Right, L	eft, Both)			
Knee Replacement (Right, Left, Both)	Col	lonoscopy: Year	Normal?: Y or N			
Other:						
Family Medical History						
Age	Diseases	If Dec	eased, Cause of Death			
	Discuses	II DCC	cased, cause of beach			
Father						
Mother						
Siblings						
Children						
Patient Social History (Please chec		Have many Defe	also nos Wools Month			
Use of Alcohol: Never Rarely Use of Tobacco: Never Daily C						
Review of Systems Do you current apply)	ly (TODAY) have ar	ny of the following	g? (Check all that			
Y_N_ Headaches Y_N_ Diarrhea Y_N_ Constipation Y_N_ Blood in Stool Y_N_ Painful Urination Y_N_ Chest Pain Y_N_ Shortness of Breath						

YN Fever YN Vomiting		
WOMEN ONLY (Check all that apply) Last PAP Smear Date: Normal Abnormal Last Mammogram Date: Normal Abnormal Last Bone Density Date: Normal Abnormal	- - -	
REASON FOR TODAYS VISIT:		
Patient Signature	Date	