

MEDICAL AND FAMILY HISTORY FORM

NAME _____ TODAY'S DATE _____ ACCT # _____

DR. BEING SEEN _____ DATE OF BIRTH _____

REASON FOR VISIT _____

Allergies

- None** Codeine Fentanyl Penicillin Propofol/Diprivan IV contrast dye Eggs
 Aspirin Demerol Morphine Sulfa Versed Latex Other _____

Past Medical Illnesses

- | | | | | |
|-----------------------------------------|------------------------------------------------|-------------------------------------------------|------------------------------------------------|--------------------------------------------|
| <input type="radio"/> None | <input type="radio"/> Acid Reflux | <input type="radio"/> Coronary artery disease | <input type="radio"/> Glaucoma | <input type="radio"/> Kidney disease |
| Cancers: | <input type="radio"/> Anxiety/Panic attacks | <input type="radio"/> Crohn's disease | <input type="radio"/> Heart attack | <input type="radio"/> Lupus |
| <input type="radio"/> Breast cancer | <input type="radio"/> Arthritis | <input type="radio"/> Depression | <input type="radio"/> Helicobacter Pylori | <input type="radio"/> Pancreatitis |
| <input type="radio"/> Cervical cancer | <input type="radio"/> Asthma | <input type="radio"/> Diabetes | <input type="radio"/> Hepatitis B | <input type="radio"/> Seizure disorder |
| <input type="radio"/> Colon cancer | <input type="radio"/> Atrial fibrillation | <input type="radio"/> Diverticulitis (infected) | <input type="radio"/> Hepatitis C | <input type="radio"/> Sleep apnea |
| <input type="radio"/> Esophageal cancer | <input type="radio"/> Barrett's esophagus | <input type="radio"/> Diverticulosis | <input type="radio"/> Hepatitis, autoimmune | <input type="radio"/> Stroke/TIA |
| <input type="radio"/> Liver cancer | <input type="radio"/> Celiac sprue | <input type="radio"/> Emphysema | <input type="radio"/> High blood pressure | <input type="radio"/> Thyroid, overactive |
| <input type="radio"/> Lung cancer | <input type="radio"/> Cirrhosis of liver | <input type="radio"/> Endometriosis | <input type="radio"/> High cholesterol | <input type="radio"/> Thyroid, underactive |
| <input type="radio"/> Prostate cancer | <input type="radio"/> Colon polyps | <input type="radio"/> Fatty liver | <input type="radio"/> HIV | <input type="radio"/> Ulcer |
| <input type="radio"/> Skin cancer | <input type="radio"/> Congestive heart failure | <input type="radio"/> Fibromyalgia | <input type="radio"/> Irritable bowel syndrome | <input type="radio"/> Ulcerative colitis |
| <input type="radio"/> Ovarian cancer | | | | <input type="radio"/> Other _____ |

Previous Procedures	Surgeries
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- | Mo/Yr performed | | | | |
|-------------------------------------------------|-----------------------------------------------|-----------------------------------------------|--------------------------------------------------|-------------------------------------------|
| <input type="radio"/> None | <input type="radio"/> Appendectomy | <input type="radio"/> Umbilical hernia repair | <input type="radio"/> Heart bypass operation | <input type="radio"/> Mastectomy |
| <input type="radio"/> Colonoscopy _____ | <input type="radio"/> Colon surgery | <input type="radio"/> Hemorrhoid surgery | <input type="radio"/> Defibrillator | <input type="radio"/> Tubal ligation |
| <input type="radio"/> EGD _____ | <input type="radio"/> Gallbladder surgery | <input type="radio"/> Liver transplant | <input type="radio"/> Heart valve rplcmt./repair | <input type="radio"/> Cataracts |
| <input type="radio"/> ERCP _____ | <input type="radio"/> Gastric bypass surgery | <input type="radio"/> Prostate surgery | <input type="radio"/> Pacemaker | <input type="radio"/> Joint surg./rplcmt. |
| <input type="radio"/> Liver biopsy _____ | <input type="radio"/> Lap band | <input type="radio"/> Tonsillectomy | <input type="radio"/> C-section | <input type="radio"/> Other _____ |
| <input type="radio"/> Esophageal capsule _____ | <input type="radio"/> Hiatal hernia surgery | <input type="radio"/> Ulcer surgery | <input type="radio"/> Hysterectomy, partial | <input type="radio"/> Other _____ |
| <input type="radio"/> Small bowel capsule _____ | <input type="radio"/> Inguinal hernia surgery | <input type="radio"/> Angioplasty/stent | <input type="radio"/> Hysterectomy, total | |

Marital status	Alcohol History	Tobacco History
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- | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="radio"/> Single <input type="radio"/> Widowed <input type="radio"/> Divorced
<input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Same-sex partner | <input type="radio"/> Never
<input type="radio"/> Less than 7 drinks per week
<input type="radio"/> More than 7 drinks per week
<input type="radio"/> I quit using alcohol | <input type="radio"/> I have never smoked cigarettes
<input type="radio"/> I quit smoking cigarettes
<input type="radio"/> I smoke less than 1 pack a day
<input type="radio"/> I smoke more than 1 pack a day |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Recreational Drug History

- I have never used recreational drugs I am currently using recreational drugs
 I have used recreational drugs in the past I have been treated for substance abuse

Occupation

Occupation _____

