Patient History Information

Today's Date: ___/____/_____

Patient Name: _____ Date of Birth: ____/____/_____

Personal & Family History	I have	Immediate Family Members				Maternal Family				Paternal Family			
		Mother	Father	Brother	Sister	Grand mother	Grand father	Aunt	Uncle	Grand mother	Grand father	Aunt	Uncle
Cancer													
Breast Cancer													
Prostate Cancer													
Diabetes													
Heart Problems													
Hypertension													
High Cholesterol													
Kidney Disease													
Respiratory Disease													
Other Medical Conditions that I have						Females only 1st day of your last menstrual period ____/____/_____ Are you currently pregnant? NO YES Are you currently breast feeding? NO YES							

Occupation: _____ My last Physical was ____months ago or _____ year(s) ago

Alcohol Use: NO YES _____ drink(s) per week for ___ year(s) Currently Exercise routinely? No Yes

Tobacco Use: NO YES ____ pack(s) per day for ___ year(s) QUIT in the year ____Smoked __ pack(s) per day for__year(s)

Current *Illegal* drug use: NO YES Marijuana Cocaine Opiates Amphetamine PCP Other: _____

Surgeries: _____

Allergies (drug, food and or environmental): _____

Preferred Pharmacy: _____ Location: _____

Medication	Strength	Dosage
Example: Sample Drug X	100mg	Once a day