

Name: _____ Date _____

MEDICATION ALLERGIES: _____

PAST MEDICAL HISTORY: Surgeries with dates: _____

Other Hospitalizations: _____

Medical Problems/ Diagnoses : please circle: High blood pressure Diabetes Coronary Artery Disease Angina
Arthritis Fibromyalgia Gout Ulcer Reflux Colitis Asthma Emphysema Chronic Bronchitis
Urinary Tract Infections Kidney stones Pneumonia TB Hay fever/allergies Hemorrhoids
Gall Bladder disease Cancer, type _____ Hepatitis A B C Irritable bowel syndrome
Migraine headaches Hypothyroidism Hyperthyroidism Depression Anxiety ADD
Other: _____

FAMILY HISTORY: list medical problems, living/deceased, age at diagnosis

Mother L / D Age _____ Medical problems: _____

Father L / D Age _____ Medical problems: _____

Siblings: _____

Maternal grandparents: _____

Paternal grandparents: _____

Children: _____

Other: _____

SOCIAL HISTORY:

Smoking: Never Current Former _____ packs/day for _____ years quit when? _____

Alcohol: None Beer Wine Liquor _____ drinks per day per week per month per year

Caffeine: None _____ cups coffee/day _____ cups/ glasses tea/day _____ sodas/day

Drug Use: Never Former (none since _____) Current Substance(s): _____ Frequency: _____

Single Married Divorced Widowed Children/ages: _____

Occupation: _____ Hobbies: _____

Exercise: Regular Occasional Never Type: _____ Frequency: _____

Additional Comments:

Reviewed by DK Levin MD _____ date _____

SI Levin MD _____ date _____