PRESTON MEDICAL ASSOCIATES

PATIENT MEDICAL HISTORY FORM
PLEASE COMPLETE ALL AREAS TO THE BEST OF YOUR KNOWLEDGE

Name: _____ DOB: _____ Date: _____

1. ILLNESS:

Have you ever had: (mark illness and give onset date)

- ❑ Anemia
- ❑ Asthma
- ❑ Arthritis/Gout
- ❑ Cancer
- ❑ Diabetes Mellitus
- ❑ Emotional Disorder
- ❑ Epilepsy (Seizures)
- ❑ Fainting Spells
- ❑ Gall Bladder Disease
- ❑ Headaches, Severe
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Digestive Problems
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Phlebitis
- ❑ Phneumonia
- ❑ Rheumatic Fever
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Venereal Disease
- ❑ Other _____

2. SURGERY:

Surgery	Date	Hospital / Doctor

7. HEALTH BEHAVIORS

	Y	N
Breast Exam		
Exercise		
Good Nutrition		
Seat Belts		

3. HOSPITALIZATIONS:

Illness/Injury	Date	Hospital / Doctor

8. SUBSTANCE USAGE

	DAILY USAGE
Alcohol	
Coffee/Tea	
Street Drugs	
Tobacco	

4. IMMUNIZATIONS:

Immunization	Date	Immunization	Date
Gardasil		Hepatitis A	
Tetanus		Hepatitis B	
Polio		Flu	
MMR		Pneumonia	
H. Influenza / Hib		Other	

9. FAMILY MEDICAL HISTORY:

	Living	Dead	Age(s)	Health?	Cause of Death
Spouse					
Children					
Father					
Mother					
Brothers					
Sisters					

5. PREGNANCY (FEMALE)

Pregnancies _____ Births: _____

Miscarriages/Abortions: _____ Living: _____

10. SCREENING PROCEDURES

(When did you last have?) Write Date.

Bone Density	Pap Smear
Cholesterol Check	Physical
EKG	Colonoscopy
Mammogram	

6. FAMILY ILLNESS: (check which apply)

- ❑ Diabetes
- ❑ Stroke
- ❑ Cancer
- ❑ Arthritis
- ❑ Blood Disease
- ❑ Peptic Ulcers
- ❑ Hay Fever / Asthma
- ❑ Thyroid Disorders
- ❑ Epilepsy Or Seizures
- ❑ Bleeding Disorders
- ❑ Kidney Disease
- ❑ High Blood Pressure
- ❑ Tuberculosis
- ❑ Lung Disease
- ❑ Emotional Disorders
- ❑ Neurologic Disorders
- ❑ Alcoholism/Addiction
- ❑ Other

Would you like to be contacted when you are due for a physical exam? ❑ Yes ❑ No