DoctorsCare

MR# _____

# PAST MEDICAL HISTORY

Have you ever been hospitalized? **Yes or No** If so for what purpose? _____
_____ When? _____
Have you ever had any previous surgeries? **Yes or No** If so for what purpose? _____
_____ When? _____
What was the date of your last tetanus shot? _____
Do you have a history of smoking? **Yes or No** How long? ____Years Currently Smoke? **Yes or No Rarely**
Are you currently taking any medications? **Yes or No** Please list _____
_____
_____
Any allergies (i.e. drug, bee stings, food)? **YES or NO** If yes, please list _____
_____
FAMILY DOCTOR / PCP (Primary Care Provider) _____

Other Doctors: _____ Specialty: _____
_____ _____

Have you ever had a history of :

| | Yourself | Family | | Yourself | Family |
|---|---|---|---|---|---|
| Skin rashes or Eczema | ____ | ____ | Back Trouble/ Injury | ____ | ____ |
| Liver Trouble | ____ | ____ | Swollen Joints | ____ | ____ |
| Hepatitis | ____ | ____ | Rheumatism or Arthritis | ____ | ____ |
| Jaundice | ____ | ____ | Fracture of Bone | ____ | ____ |
| Gallbladder Trouble | ____ | ____ | Carpal Tunnel Syndrome | ____ | ____ |
| Cancer | ____ | ____ | Tendonitis | ____ | ____ |
| High Blood Pressure | ____ | ____ | Depression | ____ | ____ |
| Heart Trouble | ____ | ____ | Nervous Breakdown | ____ | ____ |
| Heart Attack (MI) | ____ | ____ | Bipolar Disorder | ____ | ____ |
| Congestive Heart Failure | ____ | ____ | Do you wear glasses for reading or distance | ____ | ____ |
| Swelling of Ankles | ____ | ____ | Contact Lens | ____ | ____ |
| Fainting or Dizzy Spells | ____ | ____ | Color Blindness | ____ | ____ |
| Varicose Veins | ____ | ____ | Diabetes | ____ | ____ |
| Venereal Disease (STD) | ____ | ____ | Thyroid Trouble | ____ | ____ |
| Convulsions or Seizures | ____ | ____ | Stomach Ulcer | ____ | ____ |
| Head Injury | ____ | ____ | Frequent Nausea | ____ | ____ |
| Stroke (CVA) | ____ | ____ | Frequent Bowel Trouble | ____ | ____ |
| Paralysis | ____ | ____ | Frequent Diarrhea | ____ | ____ |
| Numbness of Hands or Feet | ____ | ____ | Hernia or Rupture | ____ | ____ |
| Double Vision | ____ | ____ | Difficulty Hearing | ____ | ____ |
| Glaucoma | ____ | ____ | Blood in Urine | ____ | ____ |
| Migraine Headaches | ____ | ____ | Kidney Trouble | ____ | ____ |
| Asthma | ____ | ____ | Bladder Trouble | ____ | ____ |
| Hay Fever | ____ | ____ | Bleed Easily | ____ | ____ |
| Bronchitis | ____ | ____ | Radiation Treatment | ____ | ____ |
| Shortness of Breath | ____ | ____ | Frequent or Severe Menstrual Pain | ____ | ____ |
| Tightness of Chest | ____ | ____ | Blood Disorder | ____ | ____ |
| Frequent/Chronic Cough | ____ | ____ | HIV / AIDS | ____ | ____ |
| Tuberculosis | ____ | ____ | | | |
| Emphysema | ____ | ____ | | | |

_____ _____ _____ _____
Patient or Guardian Signature & Relationship to Patient Today's Date F/U Date F/U Date

Print Patient Name _____
*FIRST NAME* *MI* *LAST NAME* *SUFFIX*

***PHARMACY CHOICE:*** _____

***ADDRESS:*** _____