

## Past Medical/Social/Family History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Past and current medical illnesses (Check all that apply)

Bleeding disorder    Congestive heart failure    Coronary artery disease (angina, heart attack)  
Diabetes (diet control)    Diabetes (diet & pills)    Diabetes (insulin required)  
Disc/spine disease    Gallbladder disease    High blood pressure    HIV/AIDS  
Kidney disease    Liver disease    Lung disease    Pancreatitis  
Parkinson's disease    Pulmonary embolism    Phlebitis    Rheumatoid arthritis  
Stomach ulcers    Stroke/TIAs    Thyroid disorder    Tumor (brain)  
Cancer (describe below)    Chemotherapy (describe below)    Other (describe below)

### Past surgeries/procedures (list below)

List all prescription medications, over the counter medications, vitamins and supplements that you currently take (include dosage and frequency taken).

The information on this form provided by the patient and/or family members was personally reviewed and/or amended by me.

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

-----Continued on reverse side -----

Do you take aspirin?  Yes  No      Do you take ibuprofen?  Yes  No

List all **allergies to medications** (check all that apply and/or write in additional information).

penicillin    amoxicillin    erythromycin    sulfa    keflex

other: \_\_\_\_\_

Are you allergic to any of the following (check all that apply and describe reaction).

shellfish    iodine    latex    MRI contrast (“dye”)    CT contrast (“dye”)

IVP contrast (“dye”)    angiogram contrast (“dye”)

other: \_\_\_\_\_

Are you a smoker?  Yes  No    How many years? (\_\_\_\_)    How many packs/day (\_\_\_\_)

Do you drink alcohol?  Yes  No    How many drinks per week? (\_\_\_\_)

Do you use illicit (“street”) drugs?  Yes  No    describe: \_\_\_\_\_

Do you engage in risky sexual behavior (unprotected sex)?  Yes  No

Are you pregnant?  Yes  No

Could you be pregnant?  Yes  No    When was your last period?

Do any of your blood relatives have (did have) any of the medical conditions noted below.

(Use the following key and circle affected family members for each condition below.)

[ M = mother, GM = grandmother, S = sister, A = aunt]

[ F = father, GF = grandfather, B = brother, U = uncle]

|                             |   |    |   |   |   |    |   |   |
|-----------------------------|---|----|---|---|---|----|---|---|
| Asthma                      | M | GM | S | A | F | GF | B | U |
| Bleeding disorder           | M | GM | S | A | F | GF | B | U |
| Brain tumor                 | M | GM | S | A | F | GF | B | U |
| Cancer                      | M | GM | S | A | F | GF | B | U |
| Depression                  | M | GM | S | A | F | GF | B | U |
| Diabetes                    | M | GM | S | A | F | GF | B | U |
| Heart disease               | M | GM | S | A | F | GF | B | U |
| High blood pressure         | M | GM | S | A | F | GF | B | U |
| Parkinson’s disease         | M | GM | S | A | F | GF | B | U |
| Rheumatoid arthritis        | M | GM | S | A | F | GF | B | U |
| Seizure disorder (epilepsy) | M | GM | S | A | F | GF | B | U |
| Stomach ulcers              | M | GM | S | A | F | GF | B | U |
| Tuberculosis (TB)           | M | GM | S | A | F | GF | B | U |