Medical History Form

Past Medical History

Height _____ Weight_____

General Health: Good____ Fair____ Poor_____
If **not good**, please explain
_____
_____
_____

When was your **most recent** visit to a doctor? _____ Why? _____

For Women: Last Mammogram Date _____Performed Where _____
For Breast Surgery Consults: Please Complete the Breast Consultation History Form

Name of family or **Primary Care doctor** _____

Do You Have **Serious illness** (please list)_____
_____

Previous Surgery (please list) If More Space Needed, Please use additional Sheet

Operation		
_____	Year _____	General or Local Anesthesia
_____	Year _____	General or Local Anesthesia
_____	Year _____	General or Local Anesthesia
_____	Year _____	General or Local anesthesia

Have you ever had **any complication** of after effects from any of these operations?
No_____ Yes _____ **If yes**, please explain _____

_____

Family History

	Age	State of health
Mother	_____	
Father	_____	
Brother(s)	_____	
Sister(s)	_____	
Children	_____	
	_____	

Have you ever had: Yes or No

Blood Disease: _____ Cancer: _____
High Blood Pressure: _____ Lung Disease: _____
Tuberculosis: _____ Mental illness: _____
Diabetes: _____ Hepatitis: _____
Epilepsy: _____ AIDS or ARC: _____
Heart Disease:_____ Bleeding Disorder_____

Medications and Drugs

What is your approximate daily consumption of the following:
Tobacco: _____
Alcohol: _____
Coffee & tea: _____
Social drugs (marijuana, cocaine, etc.)
_____

List Your Current Medications

(including blood thinners, aspirin, bufferin, birth control pills, blood pressure pills, hormones, tranquilizers, diet pills.)

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you **allergic** to any medications? No _____ Yes _____
If yes, which ones:_____
_____

Patient Name_____**Signed** _____ **Date**_____