Medical History	Name:

Chief Complaint

Medication Allergy

	Yes →		Penicillin		Aspirin		Sulfa
	None		Unknown		Other:		

Current Medications (Please list the names and dosages)

	None		Yes →

Major Hospitalizations

	Year	Surgery	Illness	Hospital	City, Country
1					
2					
3					
4					
5					

Past Medical History (Yes → X)

	Heart Attack		Liver Disease		Seizure/Epilepsy		Anemia
	Chest Pain		Kidney Disease		Asthma		Cancer
	Enlarged Heart		Gastritis		Arthritis		Menstrual Problems
	Heart Failure		Gastric Ulcer		Shoulder Pain		Blood Transfusion
	Irregular Heart Beat		Duodenal Ulcer		Low Back Pain		Other:
	Other Heart Disease		Diabetes		Headache		
	Stroke		Gout		Thyroid Disease	Last Tetanus Date:	
	High Blood Pressure		Tuberculosis		Hay Fever		

Smoking History

Have you ever smoked?		No		Yes →	Currently smoking?		Yes		No
Years Smoked:		From:		To:	From:		To:		

Family History

Disease	Grandparents	Parents	Siblings	Children
Stroke				
Hypertension				
Heart Disease				
Stomach Cancer				
Colon Cancer				
Breast Cancer				
Cervical Cancer				
Diabetes				
Asthma				
High Fat Level				
Other				

Menstrual History

Cycle:	Days:		Regular		Irregular
Last Period:		Onset Age:		Menopause:	
Number of Pregnancies:		Number of Deliveries:		Number of Miscarriages:	