Patient History Form

Name _____

Height _____ Weight_____ Blood pressure____/____

Check all that apply:

☐ Current everyday smoker ☐ Former smoker ☐ Never smoker

☐ Received annual Flu Vaccine
☐ Received Pneumonia Vaccine
☐ Colonoscopy date: _____ Sigmoidoscopy date: _____
☐ Personal history of cancer: if yes explain _____
*have you had any chemotherapy? _____
☐ Any family history pertinent to exam today? if yes explain _____

Have you ever had an ALLERGIC reaction to ANYTHING that required medical* attention? ☐ If yes, What did you react to: _____

Female patients:

No Are you or do you think you are pregnant?
Date of LMP _____
No Have you had a recent mammogram (last 2 yrs)
Date _____

Any chronic/existing medical conditions? (ex: diabetes, HTN, asthma, Lyme's Disease):

_____

turn over please……→→→→→

Prior Surgery: ☐

Type	Date

Current Medications: ☐

type	dosage

Sign: _____ Date: _____

Update initials: _____ date: _____

_____ date: _____

_____ date: _____

_____ date: _____