Medical History

Patient Name: _____ Date: _____

Please list all **allergies** to medications or food items:

Medication or Food	Reaction

Do you **smoke**? Yes / Never Smoked / Quit: _____ (year)
If so: when did you start? _____ How many packs per day? _____

Do you **drink**? Yes / No If so: How many drinks per week? _____

When was your last **flu vaccination**? _____ (month/year)
Note - If you have not had the flu vaccination, we recommend you always receive your flu shot annually.

Have you had the **pneumonia vaccination**? Yes / No If so, when? _____ (month/year)

Past Medical History: Check if you or anyone in your family currently have or have had in the past any of the following.

History	Self	Family	History	Self	Family
High Blood Pressure			Chest Pain or Heart Attack		
Diabetes			Asthma		
Protein / Sugar / Blood in Urine			Shortness of Breath		
Pain / Difficulty / Frequent Urination			Frequent Cough		
Kidney Stones			Abdominal Pain		
Rash / Itchy Skin			Diarrhea or Constipation		
Muscle Pain or Leg Cramps			Blood in Your Stool		
High Cholesterol			Hernia		
Back Pain			Hemorrhoids		
Joint Pain or Swelling			Depression / Suicide		
Numbness or Tingling in Hands or Feet			Cancer: type?		
Unplanned Weight Loss			MRSA		
Poor Appetite			VRE		
Nausea or Vomiting			Memory Loss		
Confusion			Hepatitis: type?		
HIV or Aids			Tuberculosis		