iMED HEALTHCARE ASSOCIATES PATIENT HISTORY

Date: ___________ **Name**: ____

Gender: _____ **Age**: _____ **Marital Status: Single __ Married __ Widowed __ Divorced __**

Allergies to medicines and/or food:

____

____

History of present illness:

____

____

____

CURRENT MEDICATIONS: (Include over-the-counter medications):

Drug	Dose	Frequency	Reason

PAST MEDICAL HISTORY - PROVIDE DATES

Anemia/Blood Disorder	Y	N	
Infectious Disease	Y	N	
High Blood Pressure	Y	N	
Heart Disease	Y	N	
GI Ulcers	Y	N	
Hepatitis	Y	N	
Jaundice	Y	N	
Diabetes	Y	N	
Other Endocrine Disease	Y	N	
Kidney Disease	Y	N	
Kidney Stones	Y	N	
Respiratory Disease	Y	N	
Epilepsy	Y	N	
Paralysis	Y	N	
Cancer	Y	N	
Arthritis	Y	N	
Gyn Disease	Y	N	
High Cholesterol	Y	N	
Migraines/Headaches	Y	N	

Blood Transfusions Y N ____
Hearing/Ear Problems Y N ____
Unusual Childhood Illness Y N ____
Sexually Transmitted Disease Y N ____

PAST SURGICAL HISTORY/HOSPITALIZATIONS **PROVIDE DATES**

____ ____
____ ____
____ ____
____ ____

FAMILY MEDICAL HISTORY
Indicate: Mother (M) – Father (F) – Sibling (S) – Grandparent (G)

____ Hypertension ____ High Cholesterol
____ Heart Disease ____ Kidney Disease
____ Breast Cancer ____ Diabetes
____ Colon Cancer ____ Ovarian Cancer
____ Prostate Cancer ____ Other Cancer

Indicate current health or cause and age of death

Mother _________________________________ Brother(s) ____
Father __________________________________ Sister(s)____
Grandparent(s) ____
Children____
____

IMMUNIZATION HISTORY:
Indicate last year you received immunizations

________ Tetanus ________ Measles/Mumps/Rubella
________ Hepatitis B ________ Hepatitis A
________ PPD/TB Skin Test ________ Positive/Negative Pneumonia Vaccine

SOCIAL HISTORY:
Current Employment _____________________________ Spouse Employment__________________________

HABITS:
Indicate Past/Present
________ Alcohol ________ Caffeine ________Tobacco ________ Marijuana
Other Substances ____

EXERCISE:
Type _____________________________ Frequency _____________________________

PROVIDE LAST DATE OF SCREENING TEST:
________ Mammogram ________ PSA
________ PAP Smear ________ Colonoscopy
________ Bone Density ________ Last Menstrual Period