Patient Medical History Form

Directions: Your teacher will tell you about a patient. With your class, fill out this form with the patient’s information.

1. Date of last medical exam (month, year) __________________________

2. Have you ever been hospitalized for surgery or serious illness? Yes ___ No ___
   If yes,
   Date ____________________ Reason ____________________ Hospital ____________________
   ____________________ ____________________ ____________________
   ____________________ ____________________ ____________________
   ____________________ ____________________ ____________________

3. Are you taking any medications (prescriptions or over-the-counter) regularly?
   Yes _____ No _____ If yes, what medications are you taking?
   ____________________ ____________________ ____________________
   ____________________ ____________________ ____________________
   ____________________ ____________________ ____________________

4. Do you wear glasses or contact lenses? Yes _____ No _____

5. Are you allergic to any medication or have you had any reactions?
   Yes _____ No _____ If yes, fill out the chart below.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Reaction</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Patient Medical History Form, continued

6. Are you allergic to anything else (food, pollen, dust, etc.)? Yes ____ No ____

7. Do you have or have you had any of the following:

   a. arthritis __________ Yes ____ No ____
   b. diabetes __________ Yes ____ No ____
   c. hypertension/high blood pressure __________ Yes ____ No ____
   d. high cholesterol __________ Yes ____ No ____
   e. mental illness __________ Yes ____ No ____
   f. kidney disease __________ Yes ____ No ____
   g. osteoporosis __________ Yes ____ No ____
   h. sexual/physical abuse __________ Yes ____ No ____
   i. thyroid disease __________ Yes ____ No ____
   j. HIV/AIDS __________ Yes ____ No ____
   k. heart disease/heart attack __________ Yes ____ No ____
   l. substance abuse __________ Yes ____ No ____
   m. alcoholism __________ Yes ____ No ____
   n. asthma __________ Yes ____ No ____
   o. seizures __________ Yes ____ No ____
   p. stroke __________ Yes ____ No ____
   q. anemia/blood diseases __________ Yes ____ No ____
   r. liver diseases __________ Yes ____ No ____
   s. immune problems __________ Yes ____ No ____
   t. cancer __________ Yes ____ No ____
   u. frequently tired __________ Yes ____ No ____
   v. recent weight loss __________ Yes ____ No ____
   w. other: __________

______________________________________________________________________
______________________________________________________________________
Patient Medical History Form, continued

8. For Women Only

# pregnancies _____  # live births _____
Date of last Pap Smear _________  Date of last Mammogram _______
Age periods began _______  First day of last period ______
Do you use birth control?  Yes _____  No _____
If yes, what kind? ____________________________