

Past Medical History

Year	Surgery/Hospitalization/Fractures	Reason	
			<p style="text-align: center;">Previous Tests:</p> Cardiac Catheterization: Date: _____ Colonoscopy: Date: _____ EGD: Date: _____ EKG: Date: _____ Bone density test: Date: _____ Stress test: Date: _____ Other: _____

Immunizations: (indicate date) Tetanus: _____ Pneumonia: _____ Influenza: _____
 None

Family History: fill in the following about your family's medical history

Relation	current age	If deceased, cause & age	Family Medical Conditions: Check any that apply to your family		
Father			✓	Disease	Relationship to you
Mother				Alcoholism/Drug Abuse	
Brothers				Arthritis	
				Asthma	
				Blood Disease	
				Cancer, type: _____	
				Convulsions/Seizures	
Sisters				COPD/emphysema	
				Diabetes	
				Heart Disease	
				High Cholesterol	
				High Blood Pressure	
Sons				Stroke	
				Kidney Disease	
				Mental Disorders	
Daughters				Migraine Headaches	
				Thyroid Problems	
				Other:	

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

 Signature of Patient, Parent, Guardian Please print name of patient Date