



TIMARRON FAMILY MEDICINE MEDICAL HISTORY FORM

NAME: _____

DATE OF BIRTH: _____

TODAY'S DATE: _____

OCCUPATION: _____

ARE YOU? MARRIED SINGLE PARTNER

Are you ALLERGIC to any medicines? YES NO

IF YES, please list the medicine and the type of reaction you had from taking that medicine.

List all your prescription medicines indicating the dose of each pill or tablet or liquid and when you take each medicine.

List any over-the-counter medicines, vitamins and supplements you take most days including if you take a daily aspirin:

Have you had any recent medicine changes? YES NO

IF YES, which medicines or dosages are new?

List all your current medical conditions such as high blood pressure, high cholesterol, diabetes, heart failure, hypothyroidism, back pain, arthritis, etc.

Circle any of the following conditions your parents, grandparents or siblings have had:

colon cancer	breast cancer	ovarian cancer	prostate cancer
skin cancer	pancreatic cancer	blood clots	aortic aneurysm
high blood pressure	diabetes	thyroid disorders	glaucoma
high cholesterol	heart attacks or bypass surgery before age 55		strokes

List names and ages of family members with indicated conditions above:

List all surgeries you have had and the approximate year the surgery was done.

List any times you were admitted to the hospital and list the diagnosis (reason(s)) for admission and the approximate year of the admission.

Are you a current smoker? YES NO

IF YES, how much do you smoke per day now? _____ packs per day

How many years have you smoked? _____

Do you want to quit? YES NO

Are you a former smoker? YES NO

How many years did you smoke? _____

When did you stop smoking? _____

Do you drink any alcoholic beverages? YES NO

IF YES, what types? beer wine liquor

On average, how many drinks per week? _____

Do you think you might have a problem with alcohol? YES NO

Do you have an addiction problem with any legal or illegal drugs? YES NO

When was your last immunization?

Tetanus / Pertussis _____

Pneumonia _____

Shingles _____

Flu _____

Have you ever had a colonoscopy? YES NO

IF YES, when was your last one? _____

Were you diagnosed with: POLYPS DIVERTICULOSIS NEITHER

When was your last eye exam? _____

Who is your eye doctor? _____

When was your last physical / labs (for females – pap / mammogram)?

List any specialists you see and why you see them:
