Timarron
Family Medicine
Esthetics
Regenerative Medicine

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:

_____
_____
_____

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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:

_____

_____

_____

_____