a.wise MD

medical history

name _____ **date of birth:** ___•___•_____

medicines you are taking

List prescription medicines, birth control pills, over-the-counter medicines, injections, herbal medicines, and vitamins that you are taking.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

allergies

List any drugs, medications, or allergens to which you are allergic.

1. _____ Please list allergic reaction here: _____
2. _____ Please list allergic reaction here: _____
3. _____ Please list allergic reaction here: _____
4. _____ Please list allergic reaction here: _____

hospitalizations

List serious illnesses and injuries requiring hospitalization.

Year	*Serious illness or injury*	*Name of Hospital*	*City and State*

surgeries

List any past surgeries, including gynecological procedures and C-sections.

Year	*Name of Surgery*	*Name of Hospital*	*City and State*

other past medical history

List any medical problems not mentioned above.

1. _____
2. _____
3. _____
4. _____

pregnancy history

Enter the number of:

Times Pregnant _____

Live births _____ Living children _____

Abortions _____ Miscarriages _____

Complications? ◯ **Yes** ◯ **No**

history of chickenpox infection: ◯ **Yes** ◯ **No**

health care providers

Who else have you seen for your healthcare in the past 7 years?

Year	*Name of doctor or other provider*	*Location (City, State)*	*Primary Problems Cared For*

work history

Are you working now? ◯ Yes ◯ No, I'm out of work ◯ No, I'm retired ◯ No, I've never had a job

Starting with your most recent job, what type of work have you done?

	Type of Work or Job Title	Dates From	To
1.			
2.			
3.			

smoking history

Do you smoke or use tobacco now? ◯ **Yes** ◯ **No** If yes, how much? _____ packers per day for _____ years

If you quit smoking/using tobacco, when was it? _____ *(date that you quit)*

How much did you smoke/use before you quit? _____ packers per day for _____ years

alchohol and drug history

How much alcohol do you drink, if any? _____ drinks per week

If you no longer drink alchohol, when did you quit? _____

Have you ever used other "recreational" drugs? ◯ **Yes** ◯ **No**

If yes, which drugs and when? _____

If you no longer use "recreational" drugs, when did you quit? _____

exercise history

Do you exercise? ◯ **Yes** ◯ **No** If yes, how much do you exercise per week? _____

What activities do you include in your exercise regimen? _____

your family's health

	First Name	Health is: Good	Poor	Died at	Age	Medical Problems and/or Cause of Death
Father		◯	◯	◯		
Mother		◯	◯	◯		
Paternal Grandfather		◯	◯	◯		
Paternal Grandmother		◯	◯	◯		
Maternal Grandfather		◯	◯	◯		
Maternal Grandmother		◯	◯	◯		
Brothers and Sisters		◯	◯	◯		
		◯	◯	◯		
		◯	◯	◯		
		◯	◯	◯		
Spouse		◯	◯	◯		
Children		◯	◯	◯		
		◯	◯	◯		
		◯	◯	◯		
		◯	◯	◯		
		◯	◯	◯		
Others living in household		◯	◯	◯		

Check ant illnesses where members of your family have had the following illnesses or problems:

- ◯ Alcoholism
- ◯ Anemia
- ◯ Asthma
- ◯ Deep vein thrombosis
- ◯ Depression
- ◯ Diabetes
- ◯ Drug Abuse
- ◯ Epilepsy
- ◯ Eye problems
- ◯ Glaucoma
- ◯ Heart disease
- ◯ Heart Attack
- ◯ High blood pressure
- ◯ Lung disease
- ◯ Kidney disease
- ◯ Liver disease
- ◯ Mental illness
- ◯ Stroke
- ◯ Suicide attempt
- ◯ Thyroid disease
- ◯ Cancer, tumor
  - ◯ Breast cancer
  - ◯ Lung cancer
  - ◯ Colon cancer
  - ◯ Other