Diplomate American Board of Internal Medicine   Diplomate American Board of Cardiology

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CARDIOVASCULAR DISEASE

ADULT MEDICAL HISTORY INFORMATION

Name:			Date:	OFFICE USE
Sex:	DOB:	Age:	HT:	Updates – Date – Initial
Birth				
Known Drug Allergies:				
Current Medication:				
Date last Pap Smear:		Date last Mammogram:		ADVANCE DIRECTIVE
Date last Physical:		Previous Doctor:		Date:
Number of Pregnancies:		Date last Tetanus:		Copy in Chart:

Surgeries:			**Please mark with appropriate Initial(s) Mother (M) Father (F) Brother (B) Sister (S) Maternal Grand Mother/father MGM, MGF Paternal Grandmother/ father PGM, PGF**
Do you have or have you ever had chronic Problems with:	Last Cholesterol Test:		
	YES/NO	If Y Explain	
			FAMILY HISTORY
Eyes			Cancer:
Ears			Breast:
Headaches			Prostate:
Nose			Other:
Throats			Heart Diseases:
Breathing			Heart Attack:
Heart			High Blood Pressure:
Chest			Strokes:
Lungs			Blood Diseases:
Stomach			Diabetes:
Food Digestion			Seizures:
Intestines			Mental Illness:
Rectum			Asthma:
Constipation			HIV:
Diarrhea			Osteoporosis:
Kidneys			**Please mention anything else you would like your doctor to know so he may best help you.**
Urination			
Ovaries			
Uterus			
Cervix			
Menstruation			
Blood Disorders			
Bladder			
Immune Deficiency			

Disorders			
Testicles/Penis			
Sexuality Transmitted Diseases			
Skin			
Legs - Arms			
Depression			
Emotional Illness/Problems			
Sleep Problems			
Personal/ Work Stress			

Do You Do any of the following		
Smoke:	# of cigarettes/day:	Age Started smoking:
Drink Alcohol:	# Drinks/ Day:	Week:
Use Other Drugs:	How often?	Drug Name:
Exercise:	How often?	Type Of Exercise:
Type Of Diet:		

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