401 S. Main Street, Suite C7, Alpharetta, GA 30009. Tel.: 678-319-9901

MEDICAL HISTORY FORM

Today's date:__ ___________

Last Name _______________________ **First Name** ___________________ **Middle I.** _____ **Male/Female (circle)**

Marital Status: Married/Divorced/Single/Separated/Widowed (circle)

DOB: ____________________________ **SSN:**_____________________________ **Age:** ___________

Do you Smoke? __________ **Packs per day** __________ **# Years smoked** ____________

Do you drink Alcohol? ____________________ **Drinks per day** __________________

Do you use Street Drugs _______________________ **What Drugs:**_________________________

Drink cola/coffee? _____________ **How much per day?** ________________

Drug or Food allergies?: ____

Medications:

Are you currently under medical care for any reasons? If yes, please explain:____________________________

Past Operations/Surgeries:

Surgery/Operation Performed	Year	Hospital/Doctor's Name Doctor

Hospitalizations: (except for childbirth)

Reason Hospitalized	Year	Hospital	Doctor

Past illnesses: (Please Circle)

Measles	**Diabetes**	**Chronic Pain (explain in simple words)**
Rubella (German Measles)	**Goiter, Thyroid Disease**	**Malaria/Typhoid**
Chickenpox	**Hives/Allergies**	**Other Tropical Diseases**
Mumps	**Hepatitis**	**Back/Neck Problems (what problem)**
Whooping Cough	**Eczema/Dermatitis**	**Venereal Disease**
Scarlet Fever	**Mono**	**Seizures**
Tonsillitis	**Rheumatic Fever**	**Meningitis**
Diphtheria	**Poliomyelitis**	**Ear Infections**
Asthma	**Heart Attack**	**Heart Murmur**
Glaucoma	**Bronchitis/Pleurisy**	**High Blood Pressure**
Ulcer/GERD	**Influenza**	**Low Blood Pressure**
Angina Pectoris	**Tuberculosis**	**Cancer (what type) -------------------**
Kidney Stones	**Bladder or Kidney Infection**	

Other serious illnesses or Cancer: (Please explain):__---
____ ______________

IMMUNIZATIONS with Dates: Hepatitis A ____________ Hepatitis B ___________Influenza ______________

Flu shot ________________ MMR__________________ Pneumovax (pneumonia) ___________________

Meningitis _______________ Tetanus (Td) _______________Varicella (chicken pox) shot or Illness _________

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) Date:_______________________________ Abnormal? ( ) Yes, ( ) No

Colonoscopy or Sigmoidoscopy Date:__________________ Abnormal? ( ) Yes, ( ) No

Dexascan (Osteoporosis) Date:________________________ Abnormal? ( ) Yes, ( ) No

Men: PSA (prostate) Date:_____________________________ Abnormal? ( ) Yes, ( ) No

WOMEN ONLY:
Age at first menstruation _______ Are your periods regular? Y/N, How Often? _______ How many days do your periods last?_____ How many times have you been pregnant? _____ How many children born? _____________

Mammogram Date: __________Abnormal?( ) Yes, ( ) No; Pap smear Date:___________ Abnormal? ( )Yes ( )N

Please check if any relative (parents, siblings, grandparents, children) have had any of the conditions listed below:

High blood pressure: ______	Kidney Disease: ______	Asthma: ______	Ulcers:_______
Stroke: ______	Bleeding Tendencies: ______	Tuberculosis: ___	Mental Illness:____
Cancer: ______	Seizures: ______	Colitis: ______	Gout
Emphysema: ______	Heart Disease: ______	Anemia: ______	
Diabetes: ______	Other Serious Illness:____		

Please note that medications may have unwanted side effects. You are strongly urged to bring to our attention any problem that you may be having with your medications.

____________________ _________________________ ________________________

Patient Signature **Print Name** **Date**