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Medical History Review

Patient Name: _____Today's Date: _____/_____/_____

PCP: (circle) GARBER, R O S S E L O T, B A U M E L, W H I T M A N, CRAWFORD, HARK, LU, MCCABE, LUBIN-LEVY.

PATIENT'S PAST MEDICAL HISTORY (birth, major illnesses, hospitalizations, surgeries)	
DATE:	

PATIENT'S CURRENT MEDICAL PROBLEMS OR NEW CONCERNS

PATIENT'S CURRENT MEDICATIONS (liquid/chewable/pill, dosage and frequency)

PATIENT'S ALLERGIES (medication, food, other)	
NAME OF MEDICATION/FOOD/OTHER	**TYPE OF REACTION**

FAMILY HISTORY	
Biological Mother's health history:	
Biological Father's health history:	
Sibling (name/age), major medical problems:	
1)	3)
2)	4)

IS THERE A FAMILY HISTORY OF: (please indicate relative and age of onset)
Heart attack, stroke or high cholesterol before age 60? Y / N
Sudden or unexplained death? Y / N
Chest pain or heart symptoms related to exercise or exertion? Y / N
Obesity or weight problems? Y / N
Is there any family history of diabetes? Y / N
other?