MEDICAL HISTORY INFORMATION

Touchstone Internal Medicine & Pediatrics

Name:				Date:	Medications:
Sex:	DOB:	Age:	Ht:	Wt:	
Know Drug Allergies:					
Date of Last Physical:					
Surgeries:					
Date Last Pap:		Date Last Mammogram:			
Number of Pregnancies:		LMP:			

Do you or have you ever had chronic problems with:	Yes	No	Explanation:
Eyes			
Ears			
Headaches			
Nose			
Throat			
Chest			
Lungs			
Breathing			
Heart			
Stomach			
Food Digestion			
Intestines			
Rectum			
Constipation			
Diarrhea			
Bladder			
Kidneys			
Urination			
Ovaries			
Uterus			
Cervix			
Menstruation			
Blood Disorders			
Immune Deficiency Disorder			
Testicles/Penis			
Sexually Transmitted Disease			
Skin			
Legs/Arms			
Depression			
Emotion Problems			
Sleep Problems			
Personal/Work Stress			

Please indicate family history for: Mother(M), Father(F), Sister(S), Brother(B), Grandmother(GM), Grandfather(GF)

Cancer:	Heart Disease:	HIV:
Breast:	Heart Attack:	Ulcers:
Prostate:	High Blood Pressure:	Gallbladder Disease:
Asthma:	Blood Disease:	Migraines:
Stroke:	Mental Illness:	TB:
Diabetes:	Thyroid:	Other:
Seizures:		

Smoke?	# of Cigarettes:	
Drink Alcohol?	# of Drinks per Day:	# of Drinks per Week: