TRYON MEDICAL
PARTNERS
Stronger relationships. Better health.

PATIENT MEDICAL HISTORY FORM

Past Medical History and Family History
Please indicate if you or a family member have any of the following medical problems:

	You	Family member		You	Family member
High blood pressure			Osteoporosis		
High cholesterol			Arthritis		
Heart attack			Breast cancer		
Heart arrhythmia			Colon cancer		
Congestive heart failure (CHF)			Cancer: _____		
Diabetes			Anemia		
Thyroid disease			Blood clot		
Asthma			Depression		
COPD			Anxiety		
Liver disease			Other:		
Diverticulitis					
GI bleed/stomach ulcer					
Seizure					
Stroke					

Medications/Supplements:
Please list any medications or supplements you take:

Medical Providers:
Please list any medical providers involved in your care:

Surgical History:
Please list any surgeries and approximate date performed:

Social History:

Occupation _____
Do you exercise? [ ] No [ ] Yes; How many days per week? _____
Do you follow a particular diet? _____
Do you drink caffeine? [ ] No [ ] Yes; How many cups per day? _____
Do you wear seatbelts? [ ] Always [ ] Usually [ ] Rarely

Do you drink alcohol?
[ ] No [ ] Yes; how many drinks per day/week/month? _____

Have you ever smoked cigarettes?
[ ] No [ ] Yes; how many packs per day? _____ [ ] Quit; when? _____

Have you ever used drugs for recreation?
[ ] No [ ] Yes; what kind and when? _____

Marital Status?
Married____ Single_____ Divorced_____ Widowed_____ Other_____
Children:
[ ] No [ ] Yes; Number?_____

Health Maintenance – approximate date of your last:

- ☐ Colonoscopy _____
- ☐ Women: mammogram _____
- ☐ Women: pap smear _____
- ☐ Men: prostate test (PSA) _____
- ☐ Pneumonia vaccine _____
- ☐ Tetanus vaccine _____
- ☐ Shingles vaccine _____
- ☐ Flu vaccine _____