AllCare
Primary Care & Walk-ins

MEDICAL HISTORY

Patient's Name: _____ Date of Birth:_____

MEDICAL HISTORY: **CHECK ALL THAT APPLY**

□ Abnormal Heart Rhythm	□ Fainting/Dizzy Spells	□ Kidney Failure	□ Thyroid Disease
□ Allergies	□ Fatigue	□ Lung Disease	□ Tonsilities
□ Asthma	□ Gastritis	□ Pleurisy	□ Tuberculosis
□ Arthritis	□ Headache	□ Psychiatric Illness	□ Vessel Disease
□ Cancer	□ Hearing Problems	□ Pulmonary Disease	□ Visual Disorders
□ Cholesterol/Triglyceride Disorder	□ Heart Disease	□ Rheumatic Fever	□ Weight Fluctuations
	□ High/Low Blood Pressure	□ Scarlet Fever	□ Other: note below
□ Depression	□ Influenza	□ Stomach/GI Disorder	_____
□ Diabetes	□ Injuries	□ Strokes	_____

Does or did anyone in your family have any of the following from the above list? If so, please list below:
_____

FAMILY HISTORY: (AGE, OR AGE AT DEATH) LIST SPECIFIC ILLNESS EACH HAD/HAD, OR CAUSE OF DEATH
Mother: _____ _____
Father: _____ _____
Sibling(s): _____ _____

ALLERGIES **ARE YOU ALLERGIC TO ANY MEDICATIONS OR FOODS? IF YES, PLEASE SPECIFY:**
_____

CURRENT MEDICATIONS:
Type: _____ MG/Dosage _____ Times per day _____
Type: _____ MG/Dosage _____ Times per day _____
Type: _____ MG/Dosage _____ Times per day _____
Do you or have you used Medical Marijuana (Cannabis) Yes _____ No _____

SOCIAL HISTORY:
What is your current profession? _____
Have you ever had any of the following? CHECK ALL THAT APPLY
□ Alcoholism □ Drug Addiction/Dependency □ Transfusions □ Sexually Transmitted Disease (STD)
Do you smoke? □ Yes □ No If yes, how much per day? _____ Did you smoke in the past? □ Yes □ No
If you quit, when? _____ How much per day? _____ No. of years: _____
Do you exercise? ? □ Yes □ No If yes, what type? _____ How much per week _____
Do you consume alcohol? ? □ Yes □ No Type: _____ No. of glasses: _____ day / week

SURGICAL HISTORY: **LIST TYPE OF SURGERY DATE**
_____
_____

HEALTH CARE MAINTENANCE:
Are you pregnant ? □ Yes □ No Past pregnancies: _____ Live births: _____
Date of last mammogram: _____ Date of last period: _____ Date of last pap smear: _____

_____ _____
Patient Signature Date

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