

Alan Hamilton MD PC

5425 East Bell Road, Suite 145, Scottsdale, AZ 85254-6010 602-354-3172 Fax 602-354-3173

Medical History

Name - _____

Age - _____

Date - / / 20

Medical – ___ None (or list high blood pressure, diabetes, cancer etc.)		Pregnancy History (if applicable)	
		Year	Sex
		Complications	
Surgical History – ___ None (or list the operations – appendix, hysterectomy, knee – and year)			
Allergies to Medications – ___ None (if yes, list medication and type of reaction – hives, swelling, itching etc)			
Current Prescription Medications - ___ None (or list the name, dose and directions)			
OTC Medications taken - ___ None (or list – ASA, Tylenol, ibuprofen, vitamins etc)			
Family History – list age, health status, if deceased then age at death and cause.			
Father ___ Alive – health _____ ___ Deceased – Age ___ Cause _____			
Mother ___ Alive – health _____ ___ Deceased – Age ___ Cause _____			
Sister(s) # ___		Brother(s) # ___	
Other illnesses in family - ___ None (Example – diabetes, heart troubles, cancer, high BP or cholesterol)			
Social History			
Smoke ___ Yes ___ No If yes, How much? ___ # packs/d ___ # of years. When did you stop smoking? _____			
Alcohol ___ Yes ___ No If yes, How many ? _____ drinks/week		Caffeine (coffee/soda/tea) # _____ day	
Recreational Drug Use - ___ Yes ___ No		Seatbelt use - ___ Always ___ Occasionally/never	
Exercise - ___ Yes ___ No If yes, # _____ times a week			
Occupation - _____			
Living Will – ___ Yes ___ No			
Immunizations (or attach a copy of immunization record)			
Tetanus	MMR #1	#2	Pneumovax
Hepatitis A	Hepatitis B		Influenza

Patient Signature _____

Physician Signature _____

Date _____

Date _____