Lake City Medical Group ~ Medical History

Name: _____Date of Birth: _____Todays Date: _____

DRUG ALLERGIES

FAMILY HISTORY		
	Father	Mother
Heart Disease		
High Blood Pressure		
Stroke		
Cancer		
High Cholesterol		
Diabetes		
Epilepsy / Seizures		
Asthma		
Kidney Disease		
Thyroid Disease		
Mental Illness		
Arthritis		

FAMILY HISTORY
FATHER: Living or Deceased Age:_____ Cause of death_____
MOTHER: Living or Deceased Age:_____ Cause of death_____
Sibling Brothers: # Living _____ # Deceased _____
Sibling Sisters: # Living _____ # Deceased _____

ADDITIONAL FAMILY HISTORY:

Name of previous physician: **Date of last visit:**
Date of last labs:

SURGERIES

HOSPITALIZATIONS

Reason	Date	Reason	Date

PAST MEDICAL HISTORY

Yes/ No		Yes / No		Yes / No	
	Anemia		Heart attack		Seizure disorder
	Anxiety		Heart murmur		Stroke
	Cancer		Heart palpitations		Thyroid Disease

	Cardiac Disease		High blood pressure		**List Other illnesses:**
	Chronic Pain		High cholesterol		
	Depression		High triglycerides		
	Diabetes		Kidney Disease		
	Gallbladder Disease		Liver problems		
	Gout		Lung disease		
	Headache/migraine		Prostate disease		

HABITS				**Date of last colonoscopy?**
Current smoker	Yes	No	Nicotine amount daily_____	**Date of last physical?**
Previous smoker	Yes	No	Nicotine amount daily_____	**Name of last physician?**
# Of years as a smoker? _____				
Consume Alcohol	Yes	No	Type? _____How often? _____	**MEN: Date of last prostate exam?**
Street Drugs	Yes	No	Type? _____How often? _____	**WOMEN: Date of last mammogram?**
Caffeine intake	Yes	No	Type? _____How often? _____	

Please list any additional information about yourself that you feel will help the doctor complete your evaluation: