Lawrence Family Medicine & Obstetrics
Medical History

(If space is insufficient, please ask for another sheet)

Name:_____Date:_____

Have you had any serious or chronic illnesses? Yes No

If yes, describe and age it began:

1.
2.
3.
4.
5.

Have you had any surgeries? Yes No

If yes, describe and date of surgery:

1.
2.
3.
4.
5.

Have you been hospitalized for any reason other than surgery? Yes No

If yes:

Approximate Year	Reason
1.	
2.	
3.	

Are you taking any medications, including over the counter or herbal, on an ongoing basis: Yes No

If yes, please list them:

Medication	Dose	Frequency	Condition being treated/Symptoms
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Have you had any allergies or adverse reactions to medication? Yes No

If yes please list the medication and the type of reaction:

Medication	Type of Reaction

Do you have a family history (mother, father, brothers, sisters, children) of cancer, heart disease, diabetes or other serious illnesses? Yes No

Relative	Age of Onset	Disease
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Do you currently use any of the following tobacco products? Cigarettes? Yes No
Chew? Yes No
Pipe? Yes No
Cigars? Yes No

If yes, how much? _____Have you used tobacco products in the past? Yes No
If yes how many years did you use tobacco _____

Do you use alcohol? Never Occasionally 1-2 drinks/day More than 2/day

How many days per week do you exercise? _____
What type of exercise? _____

Do you wear your seatbelt? Never Usually Always

Have you had your cholesterol checked? Yes No When? _____ Result? _____
When was your last tetanus shot? _____

If you are a female over age 21, when was your last pap smear? _____
Have you had an abnormal pap smear? Yes No If yes date:_____

If you are a female over age 40, when was your last mammogram? _____

If you are over age 50, when was your last colon exam? _____

If you are over age 65, have you been vaccinated for pneumonia? Yes No

Job/Profession	Hobbies/Interests

Are you: married single divorced other
Number of Children?_____ Number of Pregnancy's_____

What else would you like the doctor to know about yourself?

1.
2.
3.

How did you select this office for your care? _____