Horizon Family Medical Group

Medical History

Name_____ Date_____

Please list information in the spaces provided. Information is confidential and will not be released without your permission.

Medical Illnesses /Date (Example: Diabetes 1995)

_____
_____
_____
_____
_____
_____
_____

Current Medications (Example: glyburide 5 mg once a day)

Medication Name Dose Frequency

_____
_____
_____
_____
_____
_____
_____
_____

Operations / Procedures/ Hospitalizations / Dates
(Example: Tonsillectomy 1965, Pneumonia at Community Hosp 10/02**)**

_____
_____
_____
_____
_____

Indicate date last performed and if abnormal:

Pap_____
Mammogram_____
Colonoscopy _____
Stress test _____

Allergies (please indicate type of reaction)

_____
_____

Immunizations

Flu	Hepatitis
Pneumonia	Tetanus
MMR	Polio

Other_____

Personal- Social History (Please circle where appropriate)

Marital Status_____
Occupation_____
Hobbies / Interests _____
Hazardous material exposure_____

Smoking History

Never smoked / Past smoker / Present smoker
How many packs per day? _____
How many years? _____
Date stopped _____

Alcohol Use (Please circle)

Never to rarely /Light / Moderate / Heavy
Usual type of alcohol consumed _____
How much and how often?
_____

Substance Abuse Y N_____

Caffeine Y N Cups per day_____

Exercise Y N

Type and frequency _____

Family History (indicate blood relative who is affected)

Allergies_____
Arthritis / Gout_____
Asthma_____
Cancer _____
Diabetes_____
Emphysema_____
Gallbladder Disease_____
Glaucoma_____
Heart Disease_____
High Blood Pressure _____
High Cholesterol_____
Kidney Disease _____
Mental Illness_____
Migraine_____
Seizures _____
Stroke _____
TB _____
Thyroid Disease_____
Other _____
_____

Clinician's initial and date
