LOFTS MEDICAL ASSOCIATES, P.C.

Medical History

Last Name	First Name	MI	Date of Birth	Gender

MEDICATIONS

Prescription and non-prescription medicines, vitamins, home remedies, birth control, herbs

	Medication	Dose	Frequency		Medication	Dose	Frequency
1				5			
2				6			
3				7			
4				8			

ALLERGIES

	Allergen	Reaction/Side Effect		Allergen	Reaction/Side Effect
1			3		
2			4		

PERSONAL MEDICAL HISTORY

Please circle any illness/condition YOU have.

Alcoholism	Bleeding/Clotting Disorder	Depression	High Blood Pressure	Lung Disease	Seizures
Asthma	Cancer	Ear Problems	High Cholesterol	Pneumonia	Stroke
Arthritis	Diabetes	Gastrointestinal	Kidney Disease	Thyroid Disease	

SURGICAL HISTORY

	Surgery	Date
1		
2		
3		
4		

SPECIALISTS

	Doctors Name	Phone Number
1		
2		
3		
4		

TESTING

Bone Density Scan	Date:
Colonoscopy	Date:
Endoscopy	Date:
Mammogram	Date:
Eye Exam	Date:

IMMUNIZATIONS

Hepatitis A	Date:
Hepatitis B	Date:
Tetanus (Td)	Date:
Tetanus (Tdap)	Date:
Pneumovax (Pneumonia)	Date:
Varicella (Shingles)	Date:

SOCIAL HISTORY

Tobacco? **Y / N**	How Much?	How Often?	Are you interested in quitting?
Alcohol? **Y / N**	Daily?	Occasional?	Social?
Exercise? **Y / N**	Weekly?	Monthly?	

FAMILY MEDICAL HISTORY

Please circle any illness/condition immediate FAMILY has had (Grandparent, Parent, Sibling)

Alcoholism	Breast Cancer	Diabetes Type 2	High Blood Pressure	Ovary Cancer
Anemia	Colon Cancer	Epilepsy/Seizures	High Cholesterol	Prostate Cancer
Asthma	Depression	Glaucoma	Kidney Disease	Stroke
Bleeding/Clotting Disorder	Diabetes Type 1	Heart Attack	Lupus	Thyroid Disorder

Please list any current problems you have: _____

_____

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