WEISER
MEMORIAL HOSPITAL
SURGICAL & SPECIALTY CLINIC

MEDICAL HISTORY

Name:_____ Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ Other

FAMILY HISTORY *Please check all that may apply.*

	Father	Mother	Brother	Sister
Cancer	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Stroke	☐	☐	☐	☐

	Father	Mother	Brother	Sister
Seizure Disorder	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐
Mental Health	☐	☐	☐	☐

Other: _____

Other Family History: _____

PERSONAL HISTORY

ILLNESSES: *Please check all that you have been treated for.*

- Alcohol Trouble ☐
- Anxiety ☐
- Asthma ☐
- Back Trouble ☐
- Bleeding Disorder ☐
- Cancer ☐
- Chicken Pox ☐
- Depression ☐
- Diabetes ☐
- Epilepsy ☐
- Fainting Spells ☐
- German Measles ☐
- Glaucoma ☐
- Heart Disease ☐
- Heart Murmur ☐
- Hepatitis ☐
- High Blood Pressure ☐
- High Cholesterol ☐
- Kidney Trouble ☐
- Lung/Respiratory Disease ☐
- Lung Trouble ☐
- Measles ☐
- Memory Loss ☐
- Migraine ☐
- Mononucleosis ☐
- Mumps ☐
- Nervous Breakdown ☐
- Peptic Ulcer ☐
- Polio ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Sexual Diseases ☐
- Stomach Ulcer ☐
- Stroke ☐
- Thyroid Trouble ☐
- Tuberculosis (T.B.) ☐
- Urinary Tract Infection ☐
- Whooping Cough ☐
- Other Illnesses ☐

If yes, please describe:

_____

_____

SURGERIES:

Accidents/Fractures ☐

If yes, please describe:

_____

_____

_____

- Appendectomy ☐
- Back ☐
- Breast ☐
- Cataract ☐
- Colon or Intestine ☐
- Ear Tube Replacement ☐
- Gallbladder ☐
- Hernia ☐
- Heart ☐
- Hysterectomy ☐
- Prostate ☐
- Tonsillectomy ☐
- Other Surgeries ☐

If yes, please describe:

_____

_____

_____

HABITS

	How Much?
Tobacco ☐	_____
Alcohol ☐	_____
Drugs ☐	_____
Caffeine ☐	_____
Exercise ☐	_____

SOCIAL HISTORY ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Partnered

Date of Previous Screening Tests: *(If applicable)*

Pap Smear _____

Mammogram _____

Bone Density _____

Colonoscopy _____

Immunization Dates: *(If applicable)*

Pneumococcal _____

Flu _____ Tetanus _____

Ophthalmologist Visit: *(If applicable)*

Date: _____

Name: _____

ALLERGIES *Describe* _____

_____

CURRENT MEDICATIONS *(List by name, including over the counter)* _____

_____

_____

_____