Down East Community Hospital Medical Associates   Patient History Form

NAME: **Date of Birth:**   **DATE:**

Please list any medications taken (include birth control pills):

Medication Name:	Strength:	Times per day:	What is this treating:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Medications to which you are **allergic:**

Please list other **conditions or illnesses** with which you have been diagnosed:

Please list any **operations** you have had (include hernias, C-sections, tonsils):

Have you had the following:

Colonoscopy ☐ yes ☐ no When: _____ Results: _____

EKG ☐ yes ☐ no When: _____ Results: _____

Chest X-ray ☐ yes ☐ no When: _____ Results: _____

Mammogram (women) ☐ yes ☐ no When: _____ Results: _____

Pap Test (women) ☐ yes ☐ no When: _____ Results: _____

DEXA (bone density) ☐ yes ☐ no When: _____ Results: _____

PSA (men) ☐ yes ☐ no When: _____ Results: _____

Cholesterol Test ☐ yes ☐ no When: _____ Results: _____

Tetanus booster ☐ yes ☐ no When: _____

Flu Shot ☐ yes ☐ no When: _____

Pneumonia Shot ☐ yes ☐ no When: _____

Stress test ☐ yes ☐ no When: _____ Results: _____

Cardiac Catheterization ☐ yes ☐ no When: _____ Results: _____

Have you ever used tobacco: ☐ yes ☐ no What age started: _____ When stopped/Still using? _____
   If you still smoke, how much? _____ packs per day. If you used to smoke, average: _____ packs/day
How many alcoholic drinks (1 drink = 1 beer = 1 shot = 1 glass wine) _____ per _____ (day/week/month)
Family History:

Diabetes: Mother ☐ Father ☐ Grandparent ☐ Other ☐

Cancer: Mother ☐ Father ☐ Grandparent ☐ Other ☐ What type: _____

Heart Disease: Mother ☐ Father ☐ Grandparent ☐ Other ☐

High blood pressure: Mother ☐ Father ☐ Grandparent ☐ Other ☐

Thyroid Disease: Mother ☐ Father ☐ Grandparent ☐ Other ☐

Rheumatoid Arthritis: Mother ☐ Father ☐ Grandparent ☐ Other ☐

Working ☐ (job: _____) Retired ☐ (former job:_____) Disabled ☐ (from what: _____)