MILLENNIUM MEDICAL CARE

Your Health is Your Wealth

Patients Name: _____ Today's Date: _____
Social Security Number: _____ Date of Birth: _____

Past Medical History:

Previous Physician's Name: _____ Date of last exam: _____
Have you ever been hospitalized? ____Yes ____No If yes, what for?_____
Last Tuberculosis (TB) Screening? _____ Result of TB screening: _____
If positive TB screen, date of last chest x-ray:_____ Result of X-Ray: _____

Which of the following conditions are you currently being treated or have been treated for in the past:

___Heart disease/Murmur/Angina	___Shortness of breath	___High Cholesterol
___ Eye disorder/Glaucoma	___Asthma	___Seizures
___High blood pressure	___Lung problems/ cough	___Stroke
___Low blood pressure	___Sinus problems	___Headaches/ Migraines
___Heartburn (reflux)	___Seasonal allergies	___Neurological problems
___Anemia or blood problems	___Tonsillitis	___Depression/Anxiety
___Thyroid Problems	___Ear problems	___Psychiatric Care
___Kidney/Bladder problems	___Diabetes	___Liver problems/Hepatitis
___Arthritis	___Cancer	___Ulcers/colitis

Please describe any current or past medical treatment not listed above:

_____

_____

Please list your past surgeries:

_____

_____

Allergies

Are you allergic to penicillin or any other drugs? If YES please list:

_____

Medications

Please List: _____

Social and Preventive History:

Do you currently smoke or chew tobacco? ____Yes ____No If no, have you in the past? ___Yes ___No
How many packs per day? _____

Do you drink alcohol, beer, or wine? ____Yes ____No If no, have you in the past? _____Yes ____No
How many drinks per week? _____

Do you currently drink coffee and/or tea? ____Yes ____No
If yes, how many cups per day? _____

Do you exercise daily/weekly? ____Yes ____No

Do you use seatbelts while driving? ____Yes ____No

Do you wear a helmet while riding a bike? ____Yes ____No

Family History:

	Living		Age(or age at death)	List serious illnesses:
Mother:	___Yes	___No	_____	_____
Father:	___Yes	___No	_____	_____
Sisters	___Yes	___No	_____	_____
	___Yes	___No	_____	_____
Brothers	___Yes	___No	_____	_____
	___Yes	___No	_____	_____

Has any member of your family (including children and parents) had any of the following illnesses:

Illness	Which Family Member?
Anemia or blood disease	_____
Cancer	_____
Diabetes	_____
Glaucoma	_____
Heart disease	_____
High blood pressure	_____
HIV disease/ AIDS	_____
Mental Illness/ Depression	_____
Stroke	_____
Other serious illness	_____

Females: Gynecological History:

How many times have you been pregnant? _____ Date of last pap smear_____

Have you had an abnormal Pap Smear? ___Yes ___No Diagnosis: _____ Follow up:_____

Have you had a sexually transmitted disease? ___Yes ____No Diagnosis: _____

Date of last mammogram: _____ Mammogram results: _____

Have you ever had a breast biopsy? ____Yes ____No Biopsy results: _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature _____ Date: _____