LifeTime HEALTHCENTER

Medical History

Name_____ Age_____ Date of Birth_____

Current Medical Problems: _____

_____

Current Meds: _____ Allergies:_____

_____ _____

_____ _____

Status: Single Married Widowed Divorced Partnered

Occupation: _____

Ages of Children_____

Medical History: Conditions and Dates

Surgeries:_____

Hospitalizations: _____

Chronic Conditions: _____

Accidents: _____

Tobacco: Yes No Amt/Day_____

Alcohol: Yes No Amt/Day_____

Recreational Drugs: Yes No _____

Other Health Care Providers:

Primary: _____

Ob/Gyn: _____

Other:_____

Pharmacy:_____

Family Med History	Age	Present Health or Cause of Death
Father	_____	_____
Mother	_____	_____
Grandparents	_____	_____
Brother(s)	_____	_____
Sister(s)	_____	_____
Spouse	_____	_____
Children	_____	_____

Family History of: (Who?)

Diabetes _____

Heart Disease_____

High Blood Pressure_____

Bleeding Disorders_____

Kidney Disease_____

Depression_____

Substance abuse/addiction_____

Female Only

Last Period Began_____

Are you pregnant now Yes No Unsure

# of pregnancies_____ # of live births_____

Contraception Type_____

Signature_____

Date_____

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