EMERSON PRIMARY CARE OF SUDBURY

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Name:_____ DOB:_____

Allergies: _____

List current medications:_____

_____

_____

_____

_____

Medical History:_____

_____

_____

_____

_____

Past Surgical History:_____

_____

_____

_____

Immunization History:_____

_____

Do you smoke? _____ How much per day?_____ How many years? _____

How much caffeine do you have per day? _____

Do you drink alcohol? _____ How much per week?_____

How many times a week do you exercise? _____

Has anyone in your family ever had any of the following? Please list family member:

Cancer:_____ High Blood Pressure:_____

High Cholesterol:_____ Diabetes:_____

Heart Attack:_____ Stroke:_____