*7325 S. Pecos Rd Ste. #102 Las Vegas, NV 89120 Phone: (702)982-6402 Fax: (702)202-0674* [*www.chamianmedicalgroup.com*](http://www.chamianmedicalgroup.com)

**MEDICAL HISTORY FORM**

***PLEASE WRITE ALL YOUR MEDICAL HISTORY IN THIS FORM. YOU SHOULD TRANSFER THE INFORMATION HERE IF YOU HAVE A LIST OF YOUR MEDICAL HISTORY AND MEDICATIONS TO AVOID CONFUSION AND ORGANIZE YOUR DATA.***

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR YOUR VISIT**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES OR REACTIONS**: Include medications, food and other agents

 ***CHECK THIS BOX IF YOU DO NOT HAVE ANY ALLERGIES***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS:** Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs

 ***CHECK THIS BOX IF YOU ARE NOT TAKING ANY MEDICATIONS, SUPPLEMENTS OR HERBS***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication** | **Dose** | **Times per day** | **Medication** | **Dose** | **Times per day** |
|   |  |  |  |  |  |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |
|  |  |  |  |  |  |

**PAST MEDICAL HISTORY:  *CHECK THIS BOX IF YOU DO NOT HAVE ANY PAST MEDICAL HISTORY***

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**SURGICAL HISTORY:** Please indicate the ***type*** and the ***date*** of operation.

 ***CHECK THIS BOX IF YOU DO NOT HAVE ANY SURGICAL HISTORY***

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |

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Last colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result/s:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last mammogram(female only): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result/s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last PAP smear(female only): \_\_\_\_\_\_\_\_\_\_\_\_\_Result/s:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last DEXA scan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result/s:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last PSA screen (male only): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY MEDICAL HISTORY:** Please put only the disease/s concerning your family and not yours.

 ***CHECK THIS BOX IF YOU DO NOT KNOW YOUR FAMILY HISTORY OR IF YOUR FAMILY HISTORY IS UNREMARKABLE***

|  |  |  |  |
| --- | --- | --- | --- |
| **Disease** | **Family member** | **Disease** | **Family member** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**SOCIAL HISTORY:** single married divorced separated widow/er

Number of children\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of guardian (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tobacco Use: Are you a current smoker or did you used to smoke tobacco?** No Yes

If the answer is **YES**, how many pack/s per day? \_\_\_\_\_\_\_\_\_\_for how many years?\_\_\_\_\_\_\_\_\_\_\_

Quit date(if you stopped smoking already): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Tobacco: Pipe Cigar Chew how much? \_\_\_\_\_\_ for how many years? \_\_\_\_\_\_\_\_\_

Quit date(if you stopped using other tobacco products already): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol use:** Do you or did you drink alcohol? No Yes # drinks per week: \_\_\_\_\_\_\_\_\_\_\_\_\_

Quit date(If you stopped drinking alcohol already): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recreational drug use:** List if applicable\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MENTAL HEALTH HISTORY:**

 Depression Anxiety Bipolar disorder Psychosis Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT AND I ALSO ACKNOWLEDGE THAT FAILURE TO DISCLOSE ANY INFORMATION IN THIS FORM MAY COMPROMISE MY CARE.***

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Signature of Patient or Legal Guardian Date**