7325 S. Pecos Rd Ste. #102 Las Vegas, NV 89120 Phone: (702)982-6402 Fax: (702)202-0674 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

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***

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

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**