HEALTH First
MEDICAL CENTER
Syed F. Hussain M.D.

PATIENT MEDICAL HISTORY

_____ _____
Patient Name Date

_____-_____-_____ _____/_____/_____
SS# DOB

Current Medications

Drug Name	Strength	Dosage
Drug Name	Strength	Dosage
Drug Name	Strength	Dosage
Drug Name	Strength	Dosage
Drug Name	Strength	Dosage
Drug Name	Strength	Dosage
Drug Name	Strength	Dosage
Drug Name	Strength	Dosage

Medical History

Illness	Yes		Yes
Diabetes	_____	Headaches	_____
Hypertension	_____	Back Problems	_____
Heart Disease	_____	Prostate Problems	_____
Blood clots	_____	Gallbladder Disease	_____
High Cholesterol	_____	Asthma	_____
Cancer	_____	COPD	_____
Type_____		Liver Disease	_____
Osteoporosis	_____	Anemia	_____
Hepatitis	_____	Mental Illness	_____
HIV/AIDS	_____	Kidney Disease	_____
Tuberculosis	_____	Other_____	
Birth Defects	_____	_____	
Type_____			

Family History

Illness	**Yes**	**Mother / Father**
Diabetes	_____	_____/_____
Hypertension	_____	_____/_____
Heart Disease	_____	_____/_____
Blood clots	_____	_____/_____
High Cholesterol	_____	_____/_____
Cancer	_____	_____/_____
Type_____		_____/_____
Osteoporosis	_____	_____/_____
Hepatitis	_____	_____/_____
HIV/AIDS	_____	_____/_____
Tuberculosis	_____	_____/_____
Birth Defects	_____	_____/_____
Type_____		
Headaches	_____	_____/_____
Back Problems	_____	_____/_____
Prostate Problems	_____	_____/_____
Gallbladder Disease	_____	_____/_____
Asthma	_____	_____/_____
COPD	_____	_____/_____
Liver Disease	_____	_____/_____
Anemia	_____	_____/_____
Mental Illness	_____	_____/_____
Kidney Disease	_____	_____/_____

Other_____

Injuries/Illnesses

Type	Date
_____	_____
_____	_____
_____	_____

Surgical History

Type	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Immunizations	**Date**	
Tetanus-Diptheria	_____	
Hepatits A Vaccine	_____	
Varicella Vaccine	_____	
Measles-Mumps-Rubella	_____	
Influenza (flu shot)	_____	
Hepatitis B Vaccine	_____	
Pneumonia Vaccine	_____	
TB Screening Test	_____	Result:_____

Screening Tests

Test	Date	Result
Pap Smear	_____	_____
Breast Exam	_____	_____
Mammogram	_____	_____
Prostate Exam	_____	_____
PSA	_____	_____
Colonoscopy	_____	_____
DEXA Scan	_____	_____
EKG	_____	_____
Stool for Blood	_____	_____

Social History

Tobacco Use Yes_____ No_____ Quit? _____ When?_____

Illicit Drug Use Yes _____ No_____

Alcohol Yes_____ No_____ How Much? _____

Do you exercise regularly? Yes_____ No_____ How often?_____

Do you have a Living Will or Advanced Directive? Yes_____ No_____

_____ _____

Patient Signature Date