Axtell Clinic

Past History Sheet

Patient Name:_____ DOB:_____ Age:_____ Sex:_____ Phone #:_____

Major Illnesses:	Age
1.	
2.	
3.	
4.	
5.	
6.	

Major Injuries:	Age
1.	
2.	
3.	
4.	
5.	
6.	

Surgical History:	Age
1.	
2.	
3.	
4.	
5.	
6.	

Miscellaneous:	Age
1.	
2.	
3.	
4.	
5.	
6.	

Medical History (mark and date those applicable):

Headache	Gallbladder disease	Depression
Shortness of breath	Prostate problems	Gout
Heart palpitations	Bowel irregularity	Scarlet fever
Heart murmur	Incontinence	Chronic rashes
Chest pain	Overactive bladder	Rheumatic fever
Dizziness/Fainting	Frequent urination	Mumps
Peripheral vascular disease	Sexual/Menstrual dysfunction	Measles
Allergies/Hay fever	Venereal disease	Rubella
Asthma	Frequent infections	Polio
Bronchitis	Hepatitis	Diphtheria
Pneumonia	Anemia	Tetanus
Ulcer	Arthritis	
Lactose intolerance	Nervousness	

Obstetrical History: Last Menstrual Period _____ Pregnancies _____ Births ____ Miscarriages _____Sexual Preference? M or F
Last PAP Smear _____ Where _____ Normal/Abnormal _____

Social History: Marital Status _____ Occupation_____

Do you use: tobacco_____ alcohol_____ caffeine_____ If yes, how much? _____

Immunizations: Influenza _____ Pneumonia _____ Hepatitis _____ DT _____Other: _____

Allergies: _____

Family History:

Disease	Family Member	Other Diseases	Family Member
Hypertension			
High Cholesterol			
Heart Disease			
Diabetes			
Colorectal Cancer			
Breast Cancer			

PLEASE LIST ALL REGULARLY TAKEN PRESCRIPTION MEDICATIONS, OVER THE COUNTER MEDICATIONS, VITAMINS AND HERBS ON THE BACK OF THIS FORM.