Allison Win, M.D. LLC.
Patient Medical History

Past Medical History: (check all that apply) –

☐ AIDS	☐ Goiter	☐ Pneumonia
☐ Alcoholism	☐ Gonorrhea	☐ Polio
☐ Anemia	☐ Gout	☐ Prostate Problems
☐ Anorexia	☐ Heart Disease	☐ Psychiatric Care
☐ Appendicitis	☐ Hepatitis	☐ Rheumatic Fever
☐ Arthritis	☐ Hernia	☐ Scarlet Fever
☐ Asthma	☐ Herpes	☐ Sexually Transmitted Disease(STD)
☐ Bleeding Disorders	☐ High Cholesterol	☐ Stroke
☐ Breast Lump	☐ HIV Positive	☐ Suicide Attempt
☐Bronchitis	☐ Kidney Disease	☐ Thyroid Problems
☐ Bulimia	☐Liver Disease	☐Tosillitis
☐ Cancer:_____	☐ Lyme's Disease	☐ Tuberculosis
☐ Cataracts	☐ Measles	☐ Typhoid Fever
☐ Chemical Dependency	☐ Migraine Headaches	☐ Ulcers
☐ Chicken Pox	☐ Miscarriage	☐ Vaginal Infection
☐ Diabetes	☐ Mononucleosis	☐ No Medical History
☐ Emphysema	☐ Multiple Sclerosis	☐ Other
☐ Epilepsy	☐ Mumps	☐
☐ Glaucoma	☐ Pace Maker	☐

Surgical History:

Type of Surgery:	**Location of Procedure:**	**Place and Approximate Date:**
1.		
2.		
3.		
4.		
5.		

Family History:

☐ Patient Adopted	Mother	Father	Daughter	Son	Sister	Brother	Runs in Family
Arthritis	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Chemical Dependency	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐

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Alive	☐	☐	☐	☐	☐	☐	☐
Deceased	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐
State of Health:							
Age at Death:							
Cause of Death:							

Social History:

Marital Status:	**Employment:**	**Tobacco History:**	**Alcohol History:**	**Illegal Drugs:**
☐ Single	☐ Currently Employed	☐ Current Every Day Smoker	☐ Never drinks alcohol	☐ Never used illegal drugs
☐ Married	☐ Retired	☐ Current Some Day Smoker	☐ Currently drinks alcohol	☐ Currently uses illegal drugs
☐ Divorced	☐ Student	☐ Former Smoker	☐ Quit	☐ Quite less than 3 years ago
☐ Separated		☐ Never Smoker		☐ In the past only
☐ Widowed				

Medication History: *Please list all of the medications you currently take, including directions. Please include any over the counter medications, vitamins, supplements, etc.*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Allergies: *Please list your allergies, or check box if none.*

Food:	**Drug:**	**Environmental:**
☐ No Food Allergies	☐ No Drug Allergies	☐ No other allergies

Immunizations: *Please provide us with a copy of the patient's Immunizations if done elsewhere.*

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For Women Only:

Menstrual History	Obstetrical History	Birth Control
Age at first menstruation: _____	Total # of Pregnancies: _____	☐ None
Age at Menopause: _____	Total # to Full Term: _____	☐ Type used: _____
Last Menstrual Period: _____	Total # Terminations: _____	
☐ Normal flow ☐ Light flow ☐ Heavy flow ☐ Irregular Cycles ☐ Painful Periods	**Other:** Last Pap Smear: _____ Last mammography:_____ Results: _____ Result:_____	

Hospitalization:

Year	Hospital	Reason of Hospitalization & Outcome:
1.		
2.		
3.		
4.		
5.		

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, Please give approximate dates: _____

What is the year of your last Colonoscopy? _____

What is the approximate date of your last physical examination? _____

Patient Signature: _____ **Date:** _____