**Down East Community Hospital Medical Associates  Patient History Form**

**NAME:**  

**Date of Birth:**  

**DATE:**  

Please list any medications taken (include birth control pills):

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Strength</th>
<th>Times per day</th>
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Medications to which you are **allergic:**

Please list other **conditions or illnesses** with which you have been diagnosed:

Please list any **operations** you have had (include hernias, C-sections, tonsils):

**Have you had the following:**

- Colonoscopy  □ yes  □ no  When: ______ Results: ______
- EKG  □ yes  □ no  When: ______ Results: ______
- Chest X-ray □ yes  □ no  When: ______ Results: ______
- Mammogram (women) □ yes  □ no  When: ______ Results: ______
- Pap Test (women) □ yes  □ no  When: ______ Results: ______
- DEXA (bone density) □ yes  □ no  When: ______ Results: ______
- PSA (men) □ yes  □ no  When: ______ Results: ______
- Cholesterol Test □ yes  □ no  When: ______ Results: ______
- Tetanus booster □ yes  □ no  When: ______
- Flu Shot □ yes  □ no  When: ______
- Pneumonia Shot □ yes  □ no  When: ______
- Stress test □ yes  □ no  When: ______ Results: ______
- Cardiac Catheterization □ yes  □ no  When: ______ Results: ______

**Have you ever used tobacco:**  □ yes  □ no  What age started: ______ When stopped/Still using? ______

If you still smoke, how much? ______ packs per day. If you used to smoke, average: ______ packs/day

**How many alcoholic drinks** (1 drink = 1 beer = 1 shot = 1 glass wine) ______ per ______ (day/week/month)

**Family History:**

- Diabetes: Mother □ Father □ Grandparent □ Other □
- Cancer: Mother □ Father □ Grandparent □ Other □ What type: _________________________________
- Heart Disease: Mother □ Father □ Grandparent □ Other □
- High blood pressure: Mother □ Father □ Grandparent □ Other □
- Thyroid Disease: Mother □ Father □ Grandparent □ Other □
- Rheumatoid Arthritis: Mother □ Father □ Grandparent □ Other □

Working □ (job: ___________)  Retired □ (former job: ___________)  Disabled □ (from what: ___________)

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