Family Practice Associates
and
Miguel Camacho, MD PC

New/Updated Patient Medical History

NAME:_____ **AGE:**_____ **DATE:**_____

Past Medical History:	**Circle (F) for Family and/or Circle (Y) for Yourself**							
High Blood Pressure	F	Y	Heart Problems	F	Y	Hepatitis	F	Y
Diabetes	F	Y	Ulcers	F	Y	Kidney Disease	F	Y
Thyroid Disease	F	Y	Tuberculosis	F	Y	Emphysema/COPD	F	Y
Cancer	F	Y	Asthma	F	Y	HIV/AIDS	F	Y
Prostate Problems	F	Y	Anxiety	F	Y	Depression	F	Y
Chest pain	F	Y	Anemia	F	Y	Ulcerative Colitis	F	Y
Stroke	F	Y	Seizure	F	Y	Abdominal pain	F	Y
Arthritis	F	Y	Glaucoma	F	Y	Reflux/Heartburn	F	Y
Vertigo	F	Y	Migraines	F	Y	Chronic Pain	F	Y

List any other illness not mentioned above:_____

Past Surgical History: Circle any of the following surgeries you have undergone.

Tonsils	Appendix	Hysterectomy	Heart
Hernia	Colon	Bladder	Lungs
Gallbladder	C-Section	Heart	Orthopedic/Bones

List any other surgeries not mentioned above:_____

Gynecological History: Date of last menstrual period:_____
Last Pap smear:_____ Last Mammogram:_____
Number of Pregnancies:_____

Immunization History:

Hepatitis B	☐	Yes	☐	No	Date Given:	_____
Tetanus	☐	Yes	☐	No	Date Given:	_____
Pneumovax	☐	Yes	☐	No	Date Given:	_____
Influenza	☐	Yes	☐	No	Date Given:	_____

Habits: Do you smoke?_____ How much per day:_____
For how long?_____

Do you drink alcohol?_____How much?_____
What kinds?_____

Allergies: List all allergies to medication and the reaction it caused:_____
_____

What medications do you take on a daily basis? Prescription or over the counter:_____
_____
_____
_____

Patient Signature:_____ **Provider Signature:**_____