FMC
FENTON MEDICAL CENTER

PATIENT MEDICAL HISTORY

Patient Name: ______________________________ DOB: __________ Date: ______________

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

PAST MEDICAL HISTORY (Do you have any of the following medical illnesses?)

Yes	No	Medical Problem	Yes	No	Medical Problem
☐	☐	Cataracts	☐	☐	Stroke
☐	☐	Glaucoma	☐	☐	Seizure
☐	☐	Frequent Infections	☐	☐	Cancer
☐	☐	Asthma	☐	☐	Anemia (Low Blood)
☐	☐	Lung Disease	☐	☐	Sickle Cell
☐	☐	Heart Disease	☐	☐	Prior Blood Transfusions
☐	☐	Heart Murmur	☐	☐	Arthritis
☐	☐	High Cholesterol	☐	☐	Tuberculosis (TB)
☐	☐	Diabetes (High Blood Sugar)	☐	☐	Thyroid Problems
☐	☐	High Blood Pressure	☐	☐	Birth Defects
☐	☐	Kidney Disease	☐	☐	STDs
☐	☐	Depression	☐	☐	HIV / AIDS

Other: ____

FAMILY HISTORY (Do any of your family members have any of the following medical illnesses?)

Yes	No	Medical Problem	Relation	Yes	No	Medical Problem	Relation
☐	☐	Allergies	______	☐	☐	Seizures	______
☐	☐	Asthma	______	☐	☐	Cancer	______
☐	☐	Lung Disease	______	☐	☐	Anemia (Low Blood)	______
☐	☐	Heart Disease Before Age 55	______	☐	☐	Sickle Cell	______
☐	☐	High Cholesterol	______	☐	☐	Arthritis	______
☐	☐	Diabetes (High Blood Sugar)	______	☐	☐	Tuberculosis (TB)	______
☐	☐	High Blood Pressure	______	☐	☐	Thyroid Problems	______
☐	☐	Kidney Disease	______	☐	☐	Birth Defects or Hole in the Heart	______
☐	☐	Stroke	______	☐	☐	Did Anyone In Your Family Die Before Age 30	______

Other: ____

List all allergies: ____

Please list any surgeries / treatments that you have had. Please include the date.

____

____

Medications:

__________ __________ __________ __________

__________ __________ __________ __________

Pharmacy Name, Location and Number: ______________________________