M. Mark Alwan, M.D.

Patient Name_____ Age_____ Date_____

Do you take any medications on a regular basis? Yes_____ No_____
(please list)

_____

Are there any medications you are allergic to or cannot take? Yes_____ No_____
(please list)

_____

Have you ever had surgery? Yes_____ No_____
If so, what was done?

_____

Have you ever been hospitalized? Yes_____ No_____
If so, why?

_____

Past Medical History

_____Asthma	_____Diabetes	_____Osteoporosis
_____Tuberculosis	_____Thyroid Disease	_____Gallstones
_____Heart Attack	_____Jaundice	_____Drug Use
_____High Cholesterol	_____Hepatitis	_____Glaucoma
_____High Blood Pressure	_____Arthritis	_____Tobacco Use
_____Anemia	_____Mental Illness	_____Alcohol Abuse
_____Depression	_____Abnormal Pap Smear	_____Eating Disorder
_____Cancer If so, what type	_____Sexually Transmitted Infections	
_____Other (please list below)		

_____

_____

Family History

_____Diabetes	_____High Blood Pressure	_____Heart Attack
_____Osteoporosis	_____Cancer If so, what type	_____Stroke
_____Other		

_____

_____

How many times have you been pregnant?_____
How many babies have you had?_____
How many cesarean sections?_____
When was your last pap smear?_____
When was your last mammogram?_____
When was your last period?_____