Lakeside Primary Care

Medical History

Please read carefully and fill out COMPLETELY. Please Print Legibly.

Do you have an allergy or sensitivity to any medicines?
❒ Yes ❒ No If yes, list drug and reaction:

Do you take any medicine on a regular basis? ❒ Yes ❒ No
If yes, list name of drug, strength, how often taken & for what reason:

Please list dates and reasons for any major hospitalizations or surgical procedures:

Please list significant medical conditions:

FAMILY HISTORY: Include name, age & health status
(If deceased, list age of and cause of death)

Mother:

Father:

Siblings:

Children:

Check illness which have occurred in any of your blood relatives.
❒diabetes ❒cancer ❒high blood pressure
❒ heart disease ❒stroke ❒ blood disorders ❒asthma
❒neurological disease ❒anxiety/depression ❒allergies
❒ kidney disease ❒liver disease ❒alcoholism
❒other

Do you use tobacco now ? ❒ Yes ❒ No
In the past? ❒ Yes ❒No How long?
Type & daily amount?
Do you drink alcohol? ❒ Yes ❒ No
Type & weekly amount?
How Long?

Who is your:
Cardiologist:
Gynecologist:
Dentist:
Other: