Georgia Medical Associates, PC **Medical History**

Name: _____ Date: _____/_____/_____ Date of Birth: _____/____/_____

Place of Birth: _____ Age: _____ Race: _____

Religion: _____ Occupation: _____ How Long: _____

Present Marriage: _____ Previous Marriage: _____

Where and when have you traveled outside of the U.S. and Canada?

_____

Is Your:	Alive	Deceased	If deceased, cause of death
Mother	____	_____	_____
Father	____	_____	_____
Spouse	____	_____	_____
Brother(s)	____	_____	_____
Sister(s)	____	_____	_____
Children	____	_____	_____

Please list all operations:

Operation performed: _____Date: _____/_____/_____

Hospital: _____ Doctor: _____

List all times you have been admitted to a hospital overnight:

Reason Hospitalized: _____ Date: _____/_____/_____

Hospital: _____ Doctor: _____

Have you had a serious illness, injuries, broken bones, etc? Yes_____ No_____

If yes please explain: _____

List any allergies you have to drugs, foods, or other items:

_____

Do you: Smoke_____ Packs per day_____ # years smoked_____

Drink alcohol_____ Drinks per day_____

Drink cola/coffee_____ How much per day_____

(over)

Medical History

List any medications that you currently/recently use:

_____

Please check if you or any relative (parents, siblings, grandparents, and children) have had any of the conditions listed below:

☐ Sugar Diabetes	☐ Bleeding Tendencies	☐ Kidney Disease
☐ Stroke	☐ Cancer	☐ Nervous Illness
☐ Ulcers	☐ High Blood Pressure	☐ Heart Disease
☐ Allergy	☐ Tuberculosis	

Have you had any of the following illnesses (please check):

☐ Diabetes	☐ Heart Trouble	☐ Kidney Disease
☐ Glaucoma	☐ Tuberculosis	☐Cancer
☐ Bleeding Tendencies	☐ Syphilis	☐ Rheumatic Fever
☐ Pneumonia	☐ Vein Trouble	☐ Asthma
☐ Jaundice		

Women Only:

Onset date of last menstrual period _____/_____/_____

Are your periods regular? _____ How often? _____

Number of pregnancies _____

Number of miscarriages _____

Have you taken Cortisone-Type drugs? _____

Oral Contraceptives? _____

Have you received a blood transfusion? _____

The Above information is strictly confidential

_____ _____/_____/_____

(Patient Signature) (Today's Date)