Armando J. Jarquin, MD, PA

MEDICAL HISTORY

Patient's Name: _____DOB: _____

What is the reason for your visit today? _____

_____

Significant illnesses, injuries, or surgeries, and date of occurrence: _____

_____

_____

_____

Current medications dose/frequency: _____

_____

_____

Are you allergic to any medications or foods? _____

_____

Date of Last Tetanus Vaccine: _____/____/_____ Date of Last Pneumonia vaccine: _____/____/_____

Date of Last Influenza Vaccine: _____/____/_____

Have you ever had? Please check (√) if yes

□ Aids or HIV	□ Chemical Dependency	□ Heart problems	□ Phlebitis
□ Anxiety	□ Depression	□ High blood pressure	□ Rheumatic Fever
□ Arthritis	□ Diabetes	□ Kidney problems	□ Thyroid Problems
□ Asthma	□ Glaucoma, eye disease	□ Lung problems	□ Tuberculosis
□ Cancer	□ Head injury	□ Neurological disorder	□ Ulcer

□ Significant weight Loss □ Significant weight gain □ Colonoscopy (exam to detect colon cancer)

For women: Date of last Pap Smear _____/_____/____Date of last mammogram _____/_____/_____

For men: Date of last PSA and prostate exam _____/_____/_____

Have you ever smoked? _____ How many packs per day? _____ For how many years? _____

How much alcohol do you drink? _____

Have you ever used drugs? □ Yes □ No If Yes, name and frequency of use: _____

Are you sexually active? □ Yes □ No

Do you exercise safe sex precautions? □ Yes □ No

	Living?		Health Condition/cause and age of death
Mother	Yes	No	_____
Father	Yes	No	_____

Is there any family history of: Please check (√) if yes

□ Breast Cancer	□ Hereditary conditons	□ Other, please list _____
□ Diabetes	□ High blood pressure	_____
□ Heart problem	□ Intestinal Cancer	

Do you have advance directives or power of attorney? □Yes □ No

Signature: _____ Date: _____