Memorial Medical Group
a service of Comanche County Memorial Hospital

Name: _____ Date of Birth: _____

Past or Current Personal Medical History (Check all that apply)

___ Alzheimer's disease
___ Asthma
___ Cancer
___ Congestive heart failure
___ Heart attack
___ Diabetes
___ Blood clots
___ Stomach/bowel problem
___ Hepatitis B
___ Hepatitis C
___Osteoporosis
___ Stroke
___ High blood pressure
___ High cholesterol
___ Migraine headaches
___ Kidney stones
___ Seizures
___ Thyroid issues

Other illnesses or conditions not listed above: _____

Family History (Please check if anyone in your family has had of these conditions)

___ Alzheimer's disease
___ Heart Disease
___ Stroke
___ Cancer
___ High cholesterol
___Osteoporosis
___ Diabetes
___ High blood pressure
___ Other (_____)

Past Procedures (Check all that apply)

___ Tonsils removed
___ Cataract removal
___ Breast Surgery
___ Appendectomy
___ Hernia repair
___ Bladder surgery
___ Sinus surgery
___ Heart bypass
___Orthopedic surgery
___ Gallbladder removed
___ Tubal ligation
___ TURP
___ Thyroid removed
___ Heart pacemaker
___ Removal of lung
___ Gastric bypass
___ Hysterectomy
___ Vasectomy
___ Other (_____)

Social History

Do you or have you smoked in the past? Yes___ No ____
Do you drink alcohol and/or use illicit drugs? Drink alcohol ___ Use illicit drugs ___

Medications Currently Taking (please give name, dose and frequency)

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Allergies

1._____ 2._____ 3._____ 4._____