Henry E. Martinez M.D.

General, Vascular & Laparoscopic Surgery

MEDICAL HISTORY FORM

Date: ______________________________

Last Name: ___________________________________ First Name: _________________________________ MI _______
Date of Birth _____________________________
Reason for visit/symptoms: ____
____
____

PLEASE LIST ANY SERIOUS / CHRONIC CONDITIONS ☐ Diabetes ☐ Heart Disease ☐ Cancer
☐ High Blood Pressure ☐ Rectal Bleeding ☐ Abdominal Pain ☐ Breast Lump ☐ Thyroid Problems
☐ Stroke ☐ Others (please specify) ____
____

PAST SURGERIES AND DATES

SURGERIES	DATE

MEDICATIONS

List the medications you are currently taking including over the counter

Medication (Name)	Dosage (How Much?)	Frequency (How often?)	Route (How to take it?)

ALLERGIES

List allergies to medications and explain reaction

Medication (Name)	Reaction

FAMILY MEDICAL HISTORY

	Cancer (What Kind?)	Heart Disease	High Blood Pressure	Diabetes	Other
FATHER					
MOTHER					
BROTHERS					
SISTERS					
CHILDREN					

DO YOU SMOKE ☐ YES ☐ NO QUANTITY _______ DO YOU DRINK ☐ YES ☐ NO QUANTITY ________
Where you referred to our office: ☐ YES ☐ NO If Yes, by whom? ______________________________
PRIMARY CARE PHYSICIAN (PCP) ____
Preferred Pharmacy: ______________________________ ____________________________ ___________________________
Name Location Phone Number