cpacs.cosmo health center
center for pan asian community services

MEDICAL HISTORY

Name: _____

DOB: _____

Are you allergic to medicine, food, or environmental allergens? ☐ Yes ☐ No

If **yes**, please specify:

_____

_____

Do you currently smoke cigarettes (including smokeless cigarettes)? ☐ Yes ☐ No

If **yes**, how much do you smoke on average?

_____ cigarettes/day

Do you drink alcohol? ☐ Yes ☐ No

PATIENT MEDICAL HISTORY: Check if you had or have any of the following medical conditions listed below:

- ☐ Abnormal bleeding after extractions, surgery, or trauma
- ☐ AIDS or HIV positive
- ☐ Alcoholism
- ☐ Allergies or hives
- ☐ Anemia or blood disorders
- ☐ Arthritis
- ☐ Artificial joint or valve
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cancer or tumor
- ☐ Diabetes
- ☐ Emotional condition
- ☐ Epilepsy, seizures, or fainting spells
- ☐ Hay fever or sinus trouble
- ☐ Heart disease or angina
- ☐ Heart murmur, mitral valve prolapse, heart defect
- ☐ Hepatitis or other liver disease
- ☐ Herpes, cold sores, or mouth ulcers
- ☐ High or low blood pressure
- ☐ Kidney disease
- ☐ Migraine headaches or frequent headaches
- ☐ Neurologic condition
- ☐ Pacemaker
- ☐ Radiation treatment
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Tuberculosis or other lung problems
- ☐ Other:

_____

_____

CURRENT MEDICATION: Please **list** all medications you are currently taking:

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

PATIENT SURGICAL HISTORY:

_____

_____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY:

_____

_____

_____

_____

_____

_____

WOMEN ONLY:

Are you **pregnant**? ☐ Yes ☐ No

If **yes**, expected delivery date:

_____

Are you taking **hormones** or **contraceptives**?

☐ Yes ☐ No

If **yes**, please specify:

_____