WASHINGTON HEALTH SYSTEM
Washington Physicians Group

Personal Medical History

Please fill out completely

Patient Name: ____ DOB: ____________________

Personal Medical History

Check any condition YOU have presently have or have had in the past

○ Anemia ○ Arthritis/Osteoarthritis ○ Cancer, what type _____________ ○ COPD ○ Clotting Disorder ○ Congestive Heart Failure	○ Crohn's Disease ○ Diabetes ○ GERD ○ Glaucoma ○ Heart Disease ○ HIV/AIDS ○ Hypertension	○ Hepatitis ○ Peptic Ulcer ○ Seizures ○ Stoke ○ Ulcerative Colitis ○ Other:____________________ ________________________

Allergies

Do you have any allergies to medications? Yes/No

Please list allergies: ______________________________ ________________________________

______________________________ ________________________________

______________________________ ________________________________

Personal Surgical History

Check any surgery they YOU have had in the past

○ Appendectomy ○ Bariatric Surgery What type: _____________ When: ___________________ ○ Breast Surgery Right/Left Why did you have surgery: _________________________	○ C-Section ○ Coronary Artery Bypass ○ Esophagus Surgery ○ Hemorrhoid Surgery ○ Hernia Repair ○ Hysterectomy ○ Kidney Surgery	○ Prostate Surgery ○ Thyroid Surgery ○ Other: ________________________ ________________________

Family History

	Mother	Father	Siblings	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Colon Polyps							
Anemia							
Diabetes							
Blood Clots							
Heart Disease							
High Blood Pressure							
Anesthesia Reaction							
Hepatitis							
Cancer							
Other							

Smoking History

Do you smoke? Yes/No   How many per day? ________   How long have you smoked? ______
Do you vape? Yes/No   How long have you vaped? ______________

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Medications

Please list ALL medications including over the counter meds AND dosage

Drug Name	Dosage	Directions