WESTOVER HILLS CLINIC

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San Antonio, TX 78251
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PAST MEDICAL HISTORY **FAMILY HISTORY**

Please check if you have had in this column

Please indicate in this column if your Mother (M), father (F), sibling (S)

YES _____NO_____	Diabetes	___(M) _____(F) _____(S)
YES _____NO_____	Heart Disease/Heart Attack	___(M) _____(F) _____(S)
YES _____NO_____	Stroke	___(M) _____(F) _____(S)
YES _____NO_____	Breast cancer	___(M) _____(F) _____(S)
YES _____NO_____	Colon cancer	___(M) _____(F) _____(S)
YES _____NO_____	Other Cancer	___(M) _____(F) _____(S)
YES _____NO_____	High Cholesterol	___(M) _____(F) _____(S)
YES _____NO_____	Kidney Disease	___(M) _____(F) _____(S)
YES _____NO_____	Liver Disease, Hepatitis	___(M) _____(F) _____(S)
YES _____NO_____	Anemia/ Bleeding disorder/Blood clots	___(M) _____(F) _____(S)
YES _____NO_____	Asthma or COPD	___(M) _____(F) _____(S)
YES _____NO_____	Thyroid	___(M) _____(F) _____(S)
YES _____NO_____	Stomach Ulcer	___(M) _____(F) _____(S)
YES _____NO_____	Seizures	___(M) _____(F) _____(S)
YES _____NO_____	Other	___(M) _____(F) _____(S)

Illness_____

Medications/doses _____

_____

_____

_____

_____

Allergies to medications: _____NO _____YES :_____

Habits: Smoking, _____NO _____YES Former Smoker _____NO _____YES

Alcohol use, _____NO _____YES Weekly Intake: _____

OTHER _____

PAST SURGERY/ Hospitalization: _____

Preventative Care

Immunizations History: Past Tetanus Date: _____Past Pneumonia Vaccine (Over 65) _____

Past Shingles (Over 60) _____ Past Colonoscopy (Over 50) _____

Past Eye Exam (Over 60) _____Past Mammogram (Over 40) _____

Past Bone Density (Over 65) _____ Past Pap Smear (over 21) _____

PSA TEST (Male over 50) _____