PARKVIEW INTERNAL MEDICINE
14869 W. Bell Rd. Bldg. 4 Ste 101
Surprise, AZ 85374
P: (623)544-1700 F: (623)544-7544

MEDICAL HISTORY

NAME: _____ DATE: _____

LIST CURRENT MEDICATIONS

NAME	STRENGTH	FREQUENCY/DOSE

ALLERGIES *(please check if you have a history of allergies to any of the following)*

[ ] NO KNOWN DRUG ALLERGIES *OTHER MEDICATIONS NOT LISTED [ ] PENICILLIN

[ ] KEFLEX _____

[ ] MORPHINE, DEMEROL [ ] CODEINE _____

[ ] IBPROFEN (advil, mortrin) _____

[ ] TETANUS OR OTHER SERUMS _____

[ ] CIPRO,FLOXIN _____

[ ] ERYTHROMYCIN _____

[ ] SULFA DRUGS _____

[ ] IODINE _____

[ ] ASPIRIN _____

MOST RECENT (please provide dates if possible)

COMPLETE PHYSICAL: _____ PROSTATE/ RECTAL EXAM: _____

COLONOSCOPYL: _____ PAP SMEAR: _____

TETNUS: _____ FLU: _____

PNEUMONIA: _____ SHINGLES VACCINE: _____

MEDICAL HISTORY *continued…..*

LIST ALL PRIOR SURGERIES AND/OR HOSPITALIZATIONS

DATE SURGERY/ REASON FOR HOSPITAL STAY LENGTH OF STAY

YOUR PERSONAL MEDICAL HISTORY (please check if YOU have any of the following)

[ ] DIABETIES [ ] LONG TERM USE OF ANTICOAGULANTS/BLOOD THINNERS
[ ] CANCER [ ] ARTHRITIS/GOUT [ ] HEART CONDITIONS
[ ] HYPERTENSION [ ] STROKE [ ] SEIZURES [ ] HEREDITARY DISEASES
[ ] HIGH CHOLESTEROL [ ] THYROID ISSUES

*****IF YOU SELECTED CANCER, HEART CONDITONS, STROKE, OR HEREDITY ISSUES, PLEASE GIVE DATES DIAGNOSED OR OCCURANCE, SPECIFIC DISEASE OR CONDITION NAME, AND ANY OTHER INFORMATION THAT MAY BE PERTINENT TO YOUR MEDICAL CARE.***

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FAMILY MEDICAL HISTORY (please list any diseases or conditions you immediate family members had or have, along with their age or if they are alive or deceased)

FAMILY MEMBER AGE ALIVE/DECEASED MEDICAL CONDITIONS/ DISEASES
