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PATIENT HISTORY LIST

NAME: _____ DOB: _____ DATE: _____

CHRONIC PAST ILLNESSES:

LIST ALL PREVIOUS SURGERIES AND DATES:

LIST ALL DRUG ALLERGIES:

FAMILY MEDICAL HISTORY

(i.e. diabetes, hypertension, cancer, heart disease, mental illness)

MOTHER: _____

FATHER: _____

SIBLINGS: _____

SOCIAL HISTORY:

MARITAL STATUS: _____

OCCUPATION: _____

TOBACCO USE: _____ HOW MUCH: _____

ALCOHOL: _____ HOW MUCH: _____

CAFFEINE: _____ HOW MUCH: _____
(e.e. pop, coffee, tea)

LIST ALL MEDICATIONS YOU TAKE:

(i.e. birth control, blood pressure, etc.)

PAST IMMUNIZATIONS:

PNEUMOVAX: _____ DATE: _____

FLU: _____ DATE: _____

TETANUS: _____ DATE: _____

TB TINE: _____ DATE: _____

OTHER: _____ DATE: _____

OB-GYN:

MENOPAUSE: _____ BIRTH CON: _____

LAST MAMMOGRAM _____

LAST PAP _____

PREGNANCIES:

Date	Gest	Sex	Weight	Complication

ANY OTHER PROBLEMS WE SHOULD BE AWARE OF:
