La Loma
Medical Office, Inc

Comprehensive Patient Medical History Form

PERSONAL INFORMATION

Preferred Name: _____

DOB: _____ Date: _____

Current Health Concerns: _____

_____

_____

MEDICATION: (Prescription and non-prescription medications, vitamins, birth control pills, herbs and supplements.)

Medication	Dose	Frequency	Medication	Dose	Frequency

Drug Allergies or reactions to medications/foods/other agents: ☐ Yes ☐ No

Please List: _____

_____

PERSONAL MEDICAL HISTORY: Do you have any of the following?

☐ Diabetes	☐ Acid Reflux (Heartburn)	☐ Anxiety
☐ High Blood Pressure	☐ Cancer	☐ Chronic lor back pain
☐ Asthma	☐ Erectile Dysfunction	☐ Heart disease
☐ Thyroid Problems	☐ Prostate problems	☐ Cholesterol problem
☐ Depression	☐ Gout	☐ Migraines
☐ Allergies	☐ Coagulation (bleeding) problem	☐ Atrial Fibrillation

☐ Other: _____

_____