MEDICAL HISTORY FORM

Name:_____ Todays Date:_____

Birthday:_____ Physician:_____

➢ MEDICATIONS

Please list any medicines that you currently take regularly (including nonprescription, herbals, vitamins).

Medication	*Dose*	*Times Per Day*

➢ ALLERGIES OR REACTIONS TO MEDICINES/FOODS/OTHER AGENTS

Medicine/Food/Other Agent	*Reaction of Side Effect*

➢ SURGICAL HISTORY

Please list all surgeries, date of surgery, performing surgeon.

Operation	*Date*	*Surgeon*

➢ PERSONAL MEDICAL HISTORY

Please indicate whether you have had any of the following medical conditions with approximate date of illness or diagnosis.

Condition	*Date of Illness or Diagnosis*	*Condition*	*Date of Illness or Diagnosis*
Congenital Heart Disease		Emphysema	
*Specify Type		Ulcers	
Heart Attack		Coagulation: (bleeding/clotting) disorder, blood clots	
High Blood Pressure		Cancer	
Congestive Heart Failure		*Specify Type	
High Cholesterol		Alcoholism	
Diabetes		Arthritis	
Stroke		Seizures	
Kidney Disease		Mental Illness	
Thyroid problems		Other	

➢ HOSPITALIZATION HISTORY

Please list the approximate date and reason for each hospitalization.

Date	*Reason for Hospitalization*

➢ GYNECOLOGICAL HISTORY (WOMEN ONLY)

When was your last menstrual period? _____

At what age did you start having periods? _____

Do you have any concerns about your periods? _____

How many children do you have? _____

When was your last pap smear? _____

When was your last mammogram? _____

Have you ever had an abnormal pap smear? _____

Have you ever had an abnormal mammogram? _____

➢ FAMILY HISTORY

Please indicate the family member(s), (parents, grandparents, siblings, aunts, uncles), if any, affected by the following medical conditions.

Condition	*Relative*	*Condition*	*Relative*
Congenital Heart Disease		Emphysema	
*Specify Type		Ulcers	
Heart Attack		Coagulation: (bleeding/clotting) disorder, blood clots	
High Blood Pressure		Cancer	
Congestive Heart Failure		*Specify Type	
High Cholesterol		Alcoholism	
Diabetes		Arthritis	
Stroke		Seizures	
Kidney Disease		Mental Illness	
		Other	

➢ SOCIAL HISTORY- SUBSTANCES

Tobacco Use

Cigarettes: Quit: Date_____

Never Smoked

Current Smoker: packs/day_____ # of years_____

Other Tobacco (current & in past) □ Pipe □Cigar □ Snuff □ Chew

□ Current □ Quit □ Never

Drug Use

Do you use any recreational drugs (marijuana, cocaine, meth, ect)? □ No □ Yes

Have you ever used recreational drugs in the past? □ No □ Yes

➢ SOCIOECONOMICS

Occupation:_____

Education Completed: □ Grade School □ College

□ High School □ Graduate School

Marital Status: □Single □ Married □ Separated □ Divorced

□ Widowed □ Co-habiting □ Engaged

Spouse/Partner's Name: _____

Number of children: _____

Who lives at home with you? _____

Do you have any communication concerns? ☐ Yes ☐ No

If so, please explain _____

➢ SAFTY

Do you use a seatbelt? ☐ Yes ☐ No

Do you use a bike helmet regularly? ☐ Yes ☐ No ☐ NA

Is violence at home a concern? ☐ Yes ☐ No

Do you feel safe in your current relationship? ☐ Yes ☐ No ☐ NA

Do you have a gun in your home? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No

Do you have a Healthcare Power of Attorney ☐ Yes ☐ No

Do you have any communication concerns? ☐ Yes ☐ No

If so, please explain _____

➢ SEXUALITY

Are you sexuality active? ☐ Yes ☐ No

Birth control method: _____ ☐ None needed

If sexuality active, do you practice safe sex? ☐ Yes ☐ No ☐ NA

Have you ever had a sexually transmitted disease (STD's) ☐ Yes ☐ No

➢ HEALTH MAINTENCE

Please indicate when, if ever, you last had the following.

Date

Cholesterol Check _____

Colonoscopy _____

Prostate Exam (Men Only) _____

Bone Density Study _____

Eye Exam (if diabetic) _____

Foot Exam (if diabetic) _____

➢ IMMUNIZATIONS

Please indicate your most recent immunizations. Include your best estimate of the month and year for each.

Hepatitis A_____ Pneumonia (Pneumovax)_____

Hepatitis B_____ Shingles (Zostavax) _____

Tetanus _____ Other _____