MEDICAL HISTORY FORM

Patient Name: ___________________________________ **Date of Birth**: __________________________

REASON FOR VISIT:____

NAME OF EMERGENCY CONTACT:_______________________________**Relationship**_____________________**Phone**________________

FAMILY HISTORY

Has any blood relative ever had the following? (Please indicate by circling the condition(s) w/ brief description.)

Breast Cancer_______________________High blood pressure_______________Kidney Disease________________
Melanoma__________________________Heart Disease____________________Depression___________________
Other skin cancer____________________Stroke__________________________Diabetes_____________________

PAST MEDICAL HISTORY

Have you ever had the following: (Please indicate by circling the condition(s) w/ brief description.)

Heart Disease_______________________Cancer________________________________Stomach Ulcer__________
Arthritis___________________________Glaucoma______________________________Kidney Disease_________
Rheumatic Fever_____________________Asthma________________________________Thyroid Disease________
Anemia____________________________AIDS or HIV positive_____________________Stroke________________
Tuberculosis_________________________Abnormal Bleeding_______________________Diabetes ______________
Bladder infections_____________________Hepatitis____________________________Emphysema____________
High Blood Pressure ___________________Epilepsy____________________________Other lung problems_______
Heart Murmur_________________________Abnormal liver _______________________Other_________________

NAME OF PRIMARY CARE PHYSICIAN:____

LIST ANY PREVIOUS SURGERIES

Year Procedure

____________________ ____
____________________ ____

ALLERGIES TO MEDICATIONS: (please list medication and reaction): ____________________________________
____

List all medications (including dosage) you are taking including non-prescription drugs, vitamins or herbals: ______________
____
____

Are you currently taking Aspirin ☐ No ☐ Yes Reason: ________________ Are you taking Coumadin ☐ No ☐ Yes

REVIEW OF SYSTEMS (to be reviewed with the physician and/or assistant)

Do you have now or have you had within the past year: (Please indicate by circling the condition(s).

Weight Change Swollen Feet/Ankles Seizures
Dry Eyes Skin Rash Joint/Muscle Pain
Chronic Cough Chronic Diarrhea Jaundice
Swollen Lymph Nodes Chest Pain Easy Bleeding
Rapid Heart Beat Depression Easy Bruising
All Others Negative

FOR WOMEN ONLY

Currently pregnant ☐ No ☐ Yes Are you currently breast feeding ☐ No ☐ Yes Date of last mammogram _________

SOCIAL HABITS

	No	Yes	When Started	When Stopped	Amount
Tobacco Use					Packs per day
Coffee					Cups per day
Alcohol			Liquor per day	Wine per day	Beer per day
Recreational Drugs					

I verify that the above information is true and accurate to the best of my knowledge.

_____________________________________ _______________________

Patient Signature (or parent if patient is a minor) Date

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