MEDICAL HISTORY FORM

Patient Name: _____ **Date of Birth**: _____
Occupation:_____**Employer:**_____

REASON FOR VISIT:_____

EMERGENCY CONTACT:_____**Relationship**_____
Emergency Contact 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/Skin Cancer_____ Heart Disease_____ Depression_____
Blood Clots_____ 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_____
MRSA_____ Sleep Apnea_____
Depression/Anxiety/Other Psychological Disorders_____

NAME OF PRIMARY CARE PHYSICIAN:_____

LIST ANY PREVIOUS SURGERIES

Year	Procedure
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES TO MEDICATIONS: (please list medication and reaction): _____
_____
_____

MEDICAL HISTORY FORM

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 or other blood thinners? ☐ No ☐ Yes

Current Height_____ Weight_____

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	Easy Bruising	All Others Negative

FOR WOMEN ONLY

Currently pregnant ☐ No ☐ Yes Are you currently breast feeding ☐ No ☐ Yes

Number of pregnancies_____ Children_____

Are you planning future pregnancies ☐ No ☐ Yes If Yes, When:_____

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					

EXERCISE

	No	Yes	Type of Exercise	Frequency (times per week)
Do you exercise?				

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