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 _____COVID-19_____
MRSA_____ Sleep Apnea_____ Other_____
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: _____ BMI: _____

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					Per week
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