

Medical History Form

Today's Date: _____ Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____ Referring Physician: _____

Personal Medical History: Have you ever been diagnosed with the following? (Please check)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Alcohol/Drug dependence |
| <input type="checkbox"/> Heart Disease/CHF | <input type="checkbox"/> Migraines | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mental Health Issues |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Pancreatic disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Lupus/autoimmune |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Asbestos Exposure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Neurological disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin ulcers |

Other: _____

Surgical History: List operations you have had and the reason for surgery. Please give approximate date and list in chronological order, if possible, including tonsils, C-Sections, etc.

1. _____
2. _____
3. _____
4. _____

Hospitalizations, Serious illness, and injuries: Please give approximate date and list in chronological order if possible.

1. _____
2. _____
3. _____
4. _____

Have you had a blood transfusion? Yes No

Family History:

Relationship	Please circle	Age	If Deceased: Age at Death and Cause of Death	Significant Medical History
Father	Alive Deceased			
Mother	Alive Deceased			
Sibling 1:	Alive Deceased			
Sibling 2:	Alive Deceased			
Sibling 3:	Alive Deceased			
Sibling 4:	Alive Deceased			

Has any of your extended family ever had any of the following (including cousins, grandparents, aunts/uncles):

Relationship	Maternal or Paternal	Age at Onset	History of Cancer (If yes, indicate type)	History of blood clots (If yes, where)	History of excessive bleeding (if yes, where)
Grandmother					
Grandfather					
Grandmother					
Grandfather					
Aunt/Uncle					
Aunt/Uncle					
Cousin					

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Do you have an advance directive for healthcare decisions? Yes No

Social History:

Do you use nicotine? Yes No How much/how long: _____ Quit/When: _____
What type? Cigarettes Cigars Chew

Do you drink alcohol? Yes No How much/how long: _____ Quit/When: _____

Have you used drugs? Yes No What type: _____ Quit/When: _____

Marital Status: Single Married Domestic Partnership Divorced Widowed

Living Situation: Alone Roommate Spouse/Partner Significant Other With Children Parents

Immunizations: Please give date of most recent vaccination or series completion date.

Influenza: _____ Pneumonia: _____ Hepatitis A: _____ Hepatitis B: _____

Shingles: _____ Tetanus: _____ HPV: _____ Meningococcal: _____

Preventative Health:

Have you ever had a colonoscopy? Yes No

Date/location of last colonoscopy: _____ Findings: _____

Have you ever had bone density test? Yes No

Date/location of last test: _____ Findings: _____

Have you had a mammogram? Yes No

Date/location of last mammogram: _____ Findings: _____

FOR WOMEN

Menstrual History:

Date of last period: _____ Age periods began: _____ Age of Menopause: _____

Date of last Pap smear: _____ Have you ever had an abnormal Pap smear? Yes No

Number of live births: _____ Number of pregnancies: _____

Current birth control method: _____ Are you interested in preserving your fertility? Yes No

Medication Allergies: List medication and reaction.

Medication	Reaction	Medication	Reaction

Medication List: List medication, dose and how often you take it. Include non-prescriptive items and supplements.

Name	Dose	Frequency	Name	Dose	Frequency