

# Medical History Form



Name: \_\_\_\_\_ D.O.B \_\_\_\_\_ Date of Visit: \_\_\_\_\_

Vitals: Temp \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ HR \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_  
Resp \_\_\_\_\_

What is the main reason for your visit today? \_\_\_\_\_

Have you had any blood work, imaging (CT, MRI, X-ray, other) or other consultations recently that is relevant to your visit today? \_\_\_\_\_

**Medical History:** Do you have any of the following medical problems?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Stroke            | <input type="checkbox"/> Cancer          |
| <input type="checkbox"/> COPD/Emphysema      | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Hepatitis       |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Mental disorder |
| <input type="checkbox"/> Seizures            | <input type="checkbox"/> Heart Attack      | <input type="checkbox"/> Other: _____    |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Bleeding disorder |  |
| <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Acid reflux       |  |
| <input type="checkbox"/> HIV                 | <input type="checkbox"/> Kidney problems   |  |

**Surgical History:** Please list all previous surgeries:

<u>Surgery</u>	<u>Date of Surgery</u>	<u>Location of surgery</u>
_____	_____	_____
_____	_____	_____

**Medications:** Please list all medications that you are currently taking:

\_\_\_\_\_

**Social History:** What is your occupation? \_\_\_\_\_

What is your marital status?  
 Single     Married     Divorced     Separated     Widowed

Did/Do you smoke?  
 YES     NO  
If yes, how often? \_\_\_\_\_ pack/day    How long? \_\_\_\_\_ years    When did you quit? \_\_\_\_\_

Do you drink alcohol?  
 NEVER     RARELY     SOCIALLY     DAILY     HEAVY USE

Do you use any illicit drugs?  
 YES     NO \_\_\_\_\_

How much water do you drink per day? \_\_\_\_\_ glasses    Caffeine? \_\_\_\_\_ cups/glasses

**Family History:** Do any of the following run in your family?

- |   |  |                                   |   |   |  |
|---|--|-----------------------------------|---|---|--|
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Stroke   | <input type="checkbox"/> Bleeding disorder  | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Hearing loss                |
| <input type="checkbox"/> COPD/Emp<br>hysema     | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Asthma   | <input type="checkbox"/> Acid reflux        | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Problems with<br>anesthesia |
| <input type="checkbox"/> High Blood<br>Pressure | <input type="checkbox"/> High<br>Cholesterol | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart<br>Attack    | <input type="checkbox"/> Mental<br>disorder |  |
|   | <input type="checkbox"/> HIV                 |                                   | <input type="checkbox"/> Kidney<br>problems |   |  |

**Review of Systems:** Do you have any of the following symptoms?

- |   |  |   |  |  |
|---|--|---|--|--|
| <input type="checkbox"/> Hearing loss     | <input type="checkbox"/> Snoring       | <input type="checkbox"/> Itchy throat           | <input type="checkbox"/> Sneezing          | <input type="checkbox"/> Daytime<br>sleepiness |
| <input type="checkbox"/> Coughing blood   | <input type="checkbox"/> Migraines     | <input type="checkbox"/> Headache               | <input type="checkbox"/> Diarrhea          |  |
| <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Joint pain    | <input type="checkbox"/> Shortness of<br>Breath | <input type="checkbox"/> Numbness/tingling |  |
| <input type="checkbox"/> Itchy eyes       | <input type="checkbox"/> Easy Bruising |   |  |  |

**Allergies:** Please list all medications that you are allergic to:

<u>Medication</u>	<u>Reaction</u>
_____	_____