MEDICAL HISTORY FORM

Updated 9.1.2020

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY):

- ☐ AIDS/ HIV
- ☐ Alzheimer's
- ☐ Anticoagulation
- ☐ Anemia
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint(s)
- ☐ Atrial Fibrillation
- ☐ Asthma/COPD
- ☐ Bipolar
- ☐ Blood Clots
- ☐ Blood Disease
- ☐ Blood transfusions
- ☐ Bruise easily
- ☐ Cancer
- ☐ Carotid Artery Disease
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Coronary Artery Disease
- ☐ Dementia
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Epilepsy or Seizures
- ☐ Excessive Thirst
- ☐ Fainting Spells/ Dizziness
- ☐ Diarrhea
- ☐ Headaches
- ☐ Genital Herpes
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives of Rash
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pacemaker or Defibrillator
- ☐ Parathyroid Disease
- ☐ Psychiatric Condition
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Scarlet fever
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sleep Apnea
- ☐ Spina Bifida
- ☐ Stents in Heart How Many? ____
- ☐ Stents in Legs How Many? ____
- ☐ Stomach/Intestinal Disease
- ☐ Stomach Ulcers
- ☐ Bloody Stools
- ☐ Stroke
- ☐ Swelling in Limbs
- ☐ Tuberculosis
- ☐ Stomach Ulcers
- ☐ Ulcer/Wounds on Leg

PAST SURGICAL HISTORY:

HOSPITALIZATION: REASON: DATE:

_____

_____

_____

_____

_____

FAMILY HISTORY:

RELATIONSHIP: STATUS OR CONDITION:

MOTHER: _____

FATHER: _____

CHILDREN: _____

SIBLING(S): _____

GRANDMOTHER(S): _____

GRANDFATHER(S): _____

SOCIAL HISTORY:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Current Smoking – How Many Years? _____

☐ Former Smoking – Year Quit _____

☐ Alcohol Use – Year Quit _____

☐ Drug Use – Which Drug(s) _____

☐ Current Exercise

# of Children: _____

Occupation: _____

Education: _____

CURRENT MEDICATIONS:

NAME OF DRUG DOSE (STRENGTH AND FREQUENCY)

_____

_____

_____

_____

_____

NAME OF DRUG DOSE (STRENGTH AND FREQUENCY)

_____

_____

_____

_____

_____

MEDICATION ALLERGIES:

_____