Medical History Form

Patient Name: _____ Today's Date: ____/____/_____

Age: _____ Date of Birth: ___/____/_____ Gender: (Circle) Male / Female

Please list other physicians your are currently seeing and what you are seeing them for: ☐ No other physicians

Physician	Reason

Please list any medications (to include over the counter and herbal) you are currently taking: ☐ No current medications

Medication	Dose (mg, ml, etc.)	How taken (twice daily, a.m., as needed, etc.)

Please list any allergies you may have to medications, foods, plants, etc. and your reaction: ☐ No known allergies

I'm allergic to:	Reaction	Estimated Date of Onset
Are you allergic to Shellfish, Iodine or Radiographic Dye? (Circle) Yes / No		

Past Medical History: **(Check all that apply)** ☐ No Past Medical History

☐ Anemia	☐ Heart Attack (MI)	☐ Pacemaker
☐ Anxiety Disorder	☐ Heart Disease	☐ Peripheral Vascular Disease
☐ Arthritis	☐ Heart Problems	☐ Pulmonary Embolism
☐ Asthma	☐ Hepatitis	☐ Rheumatoid Arthritis
☐ Bleeding Disorder	☐ Hernia	☐ Seizures/Epilepsy
☐ Blood Clots	☐ Hypertension	☐ Stroke
☐ Cancer (Specify): _____	☐ Kidney Disease	☐ Thyroid Problems
☐ Coronary Artery Disease	☐ Leg or Foot Ulcers	☐ Tuberculosis
☐ Depression	☐ Liver Disease	☐ Ulcers (Stomach)
☐ GERD/Reflux	☐ Lung Disease	☐ Other _____
☐ Gout	☐ Migraines	☐ Other _____
☐ HIV or AIDS	☐ Osteoporosis	☐ Other _____

Continue on Reverse

When/ where was your last Colonoscopy (Month/Year)? _____/_____ _____ ☐ Not Applicable

When/ where was your last Eye Exam (Month/Year)? _____/_____ _____ ☐ Not Applicable

Last Tetanus Vaccination ____/_____ (Month / Year) Last Pneumonia Vaccination ____/_____ (Month / Year) Last Shingles Vaccination ____/_____ (Month / Year)

Gynecologic/Obstetric History (Female Only)

When/ where was your last Mammogram (Month/Year)? _____/_____ _____ ☐ Not Applicable

When/ where was your last Pap Smear (Month/Year)? _____/_____ _____ ☐ Not Applicable

# of Pregnancies _____ # of Miscarriages _____ # of Children _____

Please list the types and dates (Month/Year) of any surgeries: ☐ No prior surgeries

Type of Surgery	Month/Year of Surgery
	_____/_____
	_____/_____
	_____/_____

Any past hospitalizations OTHER THAN for surgery (reason and date)? : ☐ No past hospitalizations

Hospitalizations Reason	Month/Year of Hospitalization
	_____/_____
	_____/_____
	_____/_____

Family Medical History (Place a ✓or × in the box under the family member who has/had the health issue listed on the left)

Health Condition	Mom	Mom's Mom	Mom's Dad	Dad	Dad's Mom	Dad's Dad	Brother	Sister	Aunt Uncle
Anxiety/Depression									
Cancer (Type(s): _____)									
Diabetes									
Heart Disease/Problems									
Hypertension									
Stroke/TIA									
Other (Explain: _____)									
Other (Explain: _____)									

Do you currently use tobacco? (Circle) No / Yes If yes, what type: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chewing Tobacco

Do you have a PAST history of tobacco use? (Circle) No / Yes If yes, when did you quit? (Month/Year) _____/_____

Do you drink alcoholic beverages? (Circle) No / Yes If yes, please list the type of alcohol and how often/how much you consume: _____

Do you currently or have you ever used illicit/recreational drugs? (Circle) No / Yes

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Living arrangements: ☐ Live alone ☐ Live with someone else (Specify) _____

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Activities: _____