Medical History Form

Patient Name: _____ **DOB:** _____ **Date:**_____

Patient Medical History (Check All That Apply)

□ Alcoholism	□ Cancer	□ Gout	□ Liver Disease	□ Skin Disorder
□ Allergies	□ COPD	□ Heart Disease	□ Lung Disease	□ Stomach Ulcer
□ Anemia	□ Diabetes - I or II	□ Heart Problems	□ Measles	□ Thyroid Disorder
□ Anxiety	□ Depression	□ Hepatitis - A/B/C	□ Migraines	□ Tuberculosis
□ Arthritis	□ Eating Disorder	□ Hypertension	□ Osteoporosis	□ Other:
□ Asthma	□ Epilepsy	□ High Cholesterol	□ Pneumonia	
□ AIDS/HIV	□ Glaucoma	□ Kidney Disease	□ Stroke	

List medications you are currently taking. Including prescriptions, over-the-counter drugs, and supplements. If more space is needed for medications, allergies, or surgeries write on back of page.

Medication Name	Dose	Frequency

Allergies/Reaction	Surgeries/Dates	Hospitalizations

Family History (Specify Maternal/Paternal)

Diabetes	Yes___No___Who:	Mental Health	Yes___No___Who:
Hypertension	Yes___No___Who:	Cancer	Yes___No___Who:
Heart Disease	Yes___No___Who:	Other	Yes___No___Who:
Stroke	Yes___No___Who:		

Height: _____ **Weight:** _____

Do you/Have you: (Circle one, explain if yes)

Smoke: Yes No Cigarettes Vape Cigars Chewing Tobacco Recreational Drugs **If yes:** How much/often:

_____

Drink Caffeine: Yes No Amount/Kind: _____

Drink Alcohol: Yes No Rarely Socially Occasionally Daily

Occupation: _____

Occupational Exposure (Circle All That Apply) - Bodily Fluids Smoke/Dust Noise Asbestos Solvents

Traveled Outside The USA: Yes No Where: _____

_____ _____

Patient Signature/Parent or Legal Guardian **Date**