**Medical History Form**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current or past problems with: YES NO *(If yes, please explain)*

|  |  |  |  |
| --- | --- | --- | --- |
| YES | NO | Condition | Explain |
|  |  | General Health |  |
|  |  | Eyes |  |
|  |  | Ears/nose/throat/mouth |  |
|  |  | Heart/blood/vessels |  |
|  |  | Lungs |  |
|  |  | Stomach/bowel |  |
|  |  | Kidney |  |
|  |  | Arthritis/muscles/joints/bones |  |
|  |  | Skin |  |
|  |  | Headaches/seizures/neurological |  |
|  |  | Psychological disorder |  |
|  |  | Thyroid/diabetes/endocrine |  |
|  |  | Blood/bleeding disorder |  |
|  |  | Allergic/immunologic |  |
|  |  | Hepatitis C |  |
|  |  | HIV |  |

FEMALES: Are you pregnant? YES NO Are you planning on becoming pregnant? YES NO

Are you taking hormones or birth control pills? YES NO

Family History:

Children? YES NO If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother: Living-current age: \_\_\_\_\_\_\_\_ Deceased-Age at death: \_\_\_\_\_\_\_\_\_

Father: Living-current age: \_\_\_\_\_\_\_\_\_ Deceased-Age at death: \_\_\_\_\_\_\_\_\_

Are any family members currently patients of this practice? YES NO If yes, their names:\_\_\_\_\_\_\_\_\_\_\_\_

Check any medical conditions that occur/have occurred in your family:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Mother | Father | Blood Relatives |  | Mother | Father | Blood Relatives |
| Allergies |  |  |  | Heart Disease |  |  |  |
| Arthritis |  |  |  | High Blood Pressure |  |  |  |
| Asthma |  |  |  | Lung Disease |  |  |  |
| Cancer |  |  |  | Malignant Melanoma |  |  |  |
| Diabetes |  |  |  | Psoriasis |  |  |  |
| Eczema |  |  |  | Skin Cancer |  |  |  |
| Hayfever |  |  |  | Tuberculosis |  |  |  |

Social History:

Height \_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_ Do you live alone? YES NO

Do you smoke? YES NO Do you drink alcohol? YES NO

Do you use recreational drugs? YES NO

Hobbies/leisure activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_