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: _____

_____