MEDICAL HISTORY FORM

Patient Name____**DOB**______________**Chart#**__________**Date**__________

Reason for visit: ____

Medication Allergies:____

Current Medications: (please include over-the-counter supplements)

Name of Medication	**Dosage**	**Administration (i.e. once a day, etc.)**

Patient Past Medical History

Eyes		**Gastrointestinal**		**Endocrine**	
Glaucoma	Yes / No	Stomach/duodenal ulcers	Yes / No	Diabetes	Yes / No
		Diverticulosis	Yes / No	Insulin dependent	Yes / No
Ears, Nose, Mouth, Throat		GERD	Yes / No	Thyroid disease	Yes / No
Strep Throat	Yes / No				
		Genitourinary		**Hematological/Lymphatic**	
Cardiovascular Problems		Gonorrhea, Syphilis,		Blood Clots	Yes / No
Heart attack	Yes / No	or Genital Herpes	Yes / No	Hepatitis	Yes / No
Stroke	Yes / No	Prostate cancer	Yes / No	Type: __________	
Hypertension	Yes / No	Kidney stones	Yes / No		
		Urinary tract infection	Yes / No	**Other Problems**	
Respiratory				Cancer	Yes / No
Emphysema/COPD	Yes / No	**Neurologic Problems**		Type:___________	
Asthma	Yes / No	Convulsions, seizures	Yes / No	Type:___________	
		Back problems	Yes / No	HIV	Yes / No
		Migraines	Yes / No		

Past Surgical History:____

Females only: Last Menstrual Period: ___________Pregnancies: ___________ Births: ___________

Immunizations up-to-date: ☐ Yes ☐ No

Marital status: ☐ Single ☐ Married

Tobacco use: ☐ None ☐Chew ☐ Cigar ☐ Cigarettes Packs/day___________ # of years___________Year quit___________

Alcohol use: ☐ Yes ☐ No Average # drinks per ☐Day ☐ Week ☐ Year_________ Type: ☐ Beer ☐ Wine ☐ Hard liquor

Recreational Drugs: ☐ Yes ☐ No Type(s)____

Have you had a problem with alcohol or drugs? ☐ Yes ☐ No Been through a treatment program? ☐ Yes ☐ No ☐ N/A

Family History:

Mark which relative(s) have had the following health problems by placing a letter listed beside the problem.
Code: M = mother, F = father, B = brother, S = sister, G = grandparent, C = child

___________Anemia	___________Diabetes	
___________Bleeding disorder	___________Stroke	
___________Asthma	___________Ulcers	
___________Chronic lung disease	___________Migraines	
___________Tuberculosis	___________Obesity	
___________High blood pressure	___________Rheumatoid arthritis	
___________Heart disease	___________Glaucoma	
___________Convulsions/fits	___________Gout	
___________Thyroid problems	___________Epilepsy	
___________Prostate cancer	___________Kidney stones	
___________Cancer	___________Anesthesia problems	

Family member	Age at death	List cause of death
Father	_______	__________
Mother	_______	__________
Sisters	_______	__________
Brothers	_______	__________
Children	_______	__________

Patient Review of Systems: (are you currently having any of these problems)

Eyes		**Gastrointestinal**		**Musculoskeletal**	
Wear glasses/contacts	Yes / No	Reflux/GERD	Yes / No	Arthritis	Yes / No
Eye or eye lid infection	Yes / No	Colitis	Yes / No	Bone/joint infection	Yes / No
Other eye problems	Yes / No	Diarrhea	Yes / No	Artificial joint	Yes / No
		Liver trouble	Yes / No	Gout	Yes / No
Ears, Nose, Mouth, Throat		Constipation	Yes / No		
Ear trouble	Yes / No	Hernia	Yes / No	**Psychiatric**	
Decreased hearing	Yes / No	Hemorrhoids	Yes / No	Mental problems	Yes / No
Sinus Trouble	Yes / No	Blood in stool	Yes / No	Nervous breakdown	Yes / No
Cold symptoms	Yes / No			Depression	Yes / No
		Genitourinary			
Cardiovascular Problems		Kidney or bladder disease	Yes / No	**Hematological/Lymphatic**	
Chest pain	Yes / No	Prostate problem	Yes / No	Bleeding/bruising	
Irregular or fast heartbeat	Yes / No	Prostate cancer	Yes / No	tendency	Yes / No
High blood pressure	Yes / No	Loss of control bladder	Yes / No	Anemia	Yes / No
Arteriosclerosis	Yes / No	Loss of control bowel	Yes / No	Phlebitis	Yes / No
Heart murmur	Yes / No				
Other heart condition	Yes / No	**Skin Problems**		**Other Problems**	
		Skin Infections	Yes / No	Recent weight change	Yes / No
Respiratory		Skin lesions	Yes / No	Migraines	Yes / No
Shortness of breath	Yes / No	Eczema	Yes / No	Anesthesia problems	Yes / No
Bronchitis	Yes / No	Psoriasis	Yes / No	Night sweats	Yes / No
Pneumonia	Yes / No			Fevers/chills	Yes / No
Allergies	Yes / No	**Neurologic Problems**			
Asthma	Yes / No	Headaches	Yes / No		
Tuberculosis or exposure	Yes / No	Head injury	Yes / No		
Chronic cough	Yes / No	Paralysis of limb	Yes / No		
Other lung problems	Yes / No	Numbness/Tingling	Yes / No		

Patient/Parent/Guardian Signature____Date____________________