

MEDICAL HISTORY FORM

Name _____ DOB _____ MRN _____

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS

PATIENT HISTORY:

Cancer _____
 Hypertension _____
 Anemia _____
 Diabetes _____
 Arthritis _____
 Pneumonia _____
 Tuberculosis _____
 Rheumatic Fever _____
 Stroke _____
 Tetanus Shot up to date _____
 Heart Disease _____

ALLERGY:

Asthma _____
 Hayfever _____
 Hives _____
 Allergic to Iodine/X-ray Dye _____
 Allergic to Latex _____
 Allergic to Adhesive Tape _____

BLOOD TRANSFUSION:

Blood Transfusion _____
 Reaction to blood _____
 (If reacted please list type): _____

SOCIAL HISTORY:

Occupation: _____
 Former Occupation (if retired) _____

 Marital Status: _____
 Highest Level of Education Completed: _____
 College (number of years): _____

HABIT:

Diet Restrictions (if yes, list) _____
 Use Tobacco (if yes, list number) _____
 Use Alcohol (if yes, list amount and how often) _____
 Use Drugs (if yes, list amount and how often) _____
 Problems Sleeping (if yes, list type) _____

SEXUAL HISTORY:

HIV _____
 Syphilis _____
 Gonorrhea _____

REVIEW OF SYSTEMS:

SKIN:
 Skin lesions _____

EYES:

Blurred Vision _____
 Double Vision _____
 Wear Glasses/contacts _____

EARS:

Deafness _____
 Ringing in Ears _____
 Dizzy spells _____

NOSE & THROAT

Upper Respiratory Infections _____
 Sinusitis _____
 Tonsillitis _____
 Nose Bleeds _____

MOUTH:

Mouth Lesions _____
 Toothaches _____
 Up to date w/dentist _____

LIVER:

Jaundice/Hepatitis _____

CARDIORESPIRATORY:

Irregular Pulse _____
 Difficulty Breathing _____
 Excessive Coughing _____
 Cough up blood _____
 Night Sweats _____
 Ankle Swelling _____
 Palpitations _____
 Chest Pain _____
 Heart Attack _____
 Heart Murmur _____
 Pacemaker _____

NEUROLOGIC:

Numbness/Tingling (if yes, list locations) _____
 Convulsion/Seizures _____
 Paralysis _____
 Fainting _____
 Headaches _____
 Tremors _____

Patient Signature _____ Date _____

Name _____ DOB _____ MRN _____

GASTROINTESTINAL:

Nausea Vomiting _____
Vomiting blood _____
Abdominal Pain _____
Diarrhea _____
Constipation _____
Bloody Stool _____
Hemorrhoids _____
Peptic Ulcer/Internal bleeding

GENITOURINARY:

Incontinence _____
Frequent Urination _____
Excessive Urination at night _____
Urgency to Urinate _____
Difficult Urination _____
Kidney stones _____
Sexual dysfunction _____

MENSTRUAL:

Pregnancy(if yes, how many)

Miscarriage (if yes, how many)

Abortions (if yes, how many)

Complications with birth (if yes,
list) _____
Abnormal Menstrual cycle (if yes,
list type) _____
Living children (if yes,list number)
boys _____ girls _____

EXTREMITIES:

Varicose Veins _____
Leg Cramps _____
Deformities (if yes, list type)

PSYCHIATRIC:

Mental Illness _____
Depression _____
Nervousness _____

ENDOCRINE:

Intolerance to cold or heat _____
Excessive thirst _____
Excessive urination _____

ALLERGIES TO MEDICATIONS OR FOODS:

(List Name of Medications/Foods and Reaction):

SURGERIES/HOSPITALIZATIONS:

(List Surgeries/Hospitalizations and Approximate Dates):

ACCIDENTS/INJURIES:

(List Serious Accidents/Injuries and Approximate Dates):

Patient Signature _____ Date _____

Name _____ DOB _____ MRN _____

FAMILY HISTORY:

FAMILY MEMBER	AGE(S)	LIVING/ DECEASED	CURRENT MEDICAL CONDITIONS/ CAUSE OF DEATH
FATHER			
MOTHER			
BROTHER(S)			
SISTER(S)			
CHILDREN			

PLEASE CHECK IF ANYONE IN YOUR FAMILY HAVE OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

	FATHER	MOTHER	SISTER(S)	BROTHER(S)	CHILDREN	GRANDPARENTS
Cancer						
Diabetes						
Heart Trouble						
Seizures						
Tremors						
Kidney Disease						
Blood Disease (if yes,type)						
HIV						
Hemophilia						
Hypertension						
Stroke						
Headaches						
Arthritis						
Birth Defects						
Alzheimer's disease						
Parkinson's disease						
Multiple Sclerosis						

Patient Signature _____ Date _____

