MEDICAL HISTORY FORM

NAME_____ DATE OF BIRTH _____ AGE_____

How do you rate your general health? Excellent Good Fair Poor
Please list present health concerns: _____

_____

_____

List vitamins, non-prescription, and prescription medications that you are taking:

Medication	Dose	How many times per day	Date started

List any allergies or reactions to medications_____

When were your most recent immunizations?

Chicken Pox_____ Flu _____ Hepatitis A_____ Hepatitis B_____
Measles_____ Rubella_____ Pneumonia_____

When were you most recent screening tests?

Bone Density_____ Mammogram_____
Cholesterol_____ Pap Smear_____
Colonoscopy_____ Prostate Cancer Screen_____
Stool Test for Blood_____

List of prior surgeries and dates_____

_____

_____

_____

Please check if you have or have had any of the following medical conditions or symptoms

Blood/Lymphatic
___unexplained lumps
___easy bruising/bleeding
___clotting problem
___blood transfusions

Breast
___lump
___nipple discharge
___breast biopsy

Cardiovascular
___chest pain/discomfort
___fast heart beat
___heart attack
___high blood pressure

Ears/Eyes/Mouth
___change in vision
___hearing loss
___ringing in ears
___teeth/gum problems

Endocrine
___diabetes
___thyroid problems

Gastrointestinal
___abdominal pain
___constipation
___diarrhea
___nausea/vomiting
___rectal bleeding
___heartburn
___nausea/vomiting
___rectal bleeding

General Medical
___allergies
___cancer
___chills/fever/sweats
___dizziness
___fatigue/weakness

Genitourinary
___urinary problems
___abnormal pap smear
___vaginal bleeding
___discharge: penis/vagina

OVER

Infectious
___lyme disease
___STDs

Musculoskeletal
___muscle/joint pain
___lupus
___rheumatoid arthritis

Neurological
___headaches
___memory loss
___migraines
___numbness
___stroke

Other
___problems with sexual function

Psychiatric
___anxiety/stress
___depression
___insomnia

Respiratory
___asthma
___cough/wheezing
___difficulty breathing

Skin
___acne
___acne rosacea
___mole change
___rash

Women's Health
___number of pregnancies
___number of deliveries
___number of miscarriages
___terminated pregnancies

Social History
Tobacco use: ___never ___quit date ___current ___packs/day ___number of years
Alcohol use: ___never ___social ___number of drinks/week
Caffeine use: ___none ___cups of coffee/tea/soda per day
Seatbelt use: ___never ___always ___sometimes
Bicycle helmet use: ___never ___always ___sometimes
Exercise: ___daily ___never ___sometimes

Occupation: _____ Years of education: _____
Who lives at home with you? _____

Family History
Please indicate the current status of your immediate family members:

	Alive(age)	Deceased(age)	Cause of death
Mother			
Father			
Sister(s)			
Brother(s)			

Please indicate if your grandparents, parents, siblings or children have had any other the following:
(please specify who has had any of the following)

Alcoholism_____
Anemia_____
Arthritis_____
Asthma_____
Autoimmune Disorder_____
Birth Defects_____
Cancer (type)_____
_____
Dementia_____
Depression_____
Diabetes_____
Other_____

Hearing Problems_____
Heart Attack_____
High Blood Pressure_____
High Cholesterol_____
Kidney Disease_____
Muscle Disease_____
Osteoporosis_____
Seizures_____
Stroke_____
Thyroid Disorder_____
Tuberculosis_____