# MEDICAL HISTORY

Name ______________________ SS # ______________________ Birth Date ______________

## DRUG ALLERGIES

______________________

______________________

______________________

## CURRENT MEDS

Prescription: ______________________

______________________

Over-the-Counter: ______________________

## IMMUNIZATIONS (YEAR LAST RECEIVED IF KNOWN)

Influenza ______________________

Pneumonia ______________________

Hepatitis ______________________

## FAMILY HISTORY

| | FATHER | MOTHER | FATHER'S PARENTS | MOTHER'S PARENTS | SIBLINGS | CHILDREN |
|---|---|---|---|---|---|---|
| Heart disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bleeding disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thyroid disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mental illness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Parkinson's disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Alzheimer's disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ALS | | | | | | |

Age at death ______________________

Cause of death ______________________

## HOSPITALIZATION OR SURGERY

| Reason | Date | Reason | Date |
|---|---|---|---|
| | | | |
| | | | |

## INJURIES

| Description | Date | Description | Date |
|---|---|---|---|
| | | | |
| | | | |

## PREVIOUS MEDICAL DIAGNOSES

- ☐ Scarlet fever
- ☐ Rheumatic fever
- ☐ Endocrine disease
- ☐ Venereal disease
- ☐ Thyroid disease
- ☐ Renal disease
- ☐ Liver disease
- ☐ Anemia
- ☐ Gout
- ☐ Stroke
- ☐ Bleeding disorder
- ☐ Arrhythmia
- ☐ Psoriasis / Eczema
- ☐ Urinary tract disorder
- ☐ Epilepsy
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ COPD
- ☐ Ulcer
- ☐ Cancer
- ☐ Heart murmur
- ☐ Enlarged prostate
- ☐ Glaucoma / Cataracts
- ☐ MI
- ☐ Orthopnea
- ☐ TB / Lung
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Diabetes
- ☐ Hepatitis
- ☐ TIAs

## PREVIOUS MEDICAL SYMPTOMS

- ☐ Constipation
- ☐ Incontinence / Bladder
- ☐ Incontinence / Bowel
- ☐ Dizziness
- ☐ Failing episodes
- ☐ Loss of consciousness
- ☐ Fatigue
- ☐ Anxiety
- ☐ Shortness of breath
- ☐ Heart palpitations
- ☐ Digestive problems
- ☐ Hearing loss
- ☐ Sexual dysfunction
- ☐ Chest pain / angina
- ☐ Sleep disorders
- ☐ Depression
- ☐ Hallucination
- ☐ Paranoia

## HABITS

Smoke: Packs daily ______________ How long ______________ When stopped ______________

Exercise routine: ______________ Diet: ______________

Coffee: Cups daily ______________ Alcohol: Type / Amount ______________ Sleep pattern: ______________

Do you have a Living Will? Y / N

Do you have a Power of Attorney? Y / N