# Medical History

Name: _____ DOB:_____/_____/_____ Date:_____/_____/_____

What is the reason for today's visit?_____

Are you allergic to any medication? (If yes, please list medications and reactions below) ___Yes ___ No Are you pregnant? ___Yes ___No

_____

Please list below current medications you are taking, including prescriptions, over the counter meds, vitamins, herbal supplements, etc:

1._____ 3._____ 5._____

2._____ 4._____ 6._____

Have you ever had a history of: I have had no significant medical problems- ◯ Yes

| | | | | | |
|---|---|---|---|---|---|
| AIDS | ◯ Yes | Epilepsy (Seizures) | ◯ Yes | Multiple Sclerosis | ◯ Yes |
| Alcoholism | ◯ Yes | Glaucoma | ◯ Yes | Pneumonia | ◯ Yes |
| Asthma | ◯ Yes | Gout | ◯ Yes | Prostate Problems | ◯ Yes |
| Anorexia | ◯ Yes | Heart Disease | ◯ Yes | Psychiatric Care | ◯ Yes |
| Arthritis | ◯ Yes | Hepatitis | ◯ Yes | Strep Throat | ◯ Yes |
| Bleeding Disorder | ◯ Yes | Herpes | ◯ Yes | Stroke | ◯ Yes |
| Breast Lump | ◯ Yes | High Cholesterol | ◯ Yes | Suicide Attempt | ◯ Yes |
| Bronchitis | ◯ Yes | HIV Positive | ◯ Yes | Thyroid Problems | ◯ Yes |
| Bulimia | ◯ Yes | Hypertension | ◯ Yes | Tonsillitis | ◯ Yes |
| Cancer | ◯ Yes | Kidney Disease | ◯ Yes | Ulcers | ◯ Yes |
| Chemical Dependency | ◯ Yes | Liver Disease | ◯ Yes | Urinary Tract Infections | ◯ Yes |
| Diabetes I or II | ◯ Yes | Migraines | ◯ Yes | Vaginal Infection | ◯ Yes |
| Emphysema | ◯ Yes | Mononucleosis | ◯ Yes | Venereal Disease | ◯ Yes |

List any other diseases or condition: _____

Have you had surgery in the last 3 month? ___Yes ___ No Have you ever had skin cancer surgery? ___Yes ___ No

**Surgical History** **Date (Month/Year)**

1._____ _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

**Social History**

Do you use alcohol? ___Yes ___ No
Have you ever used alcohol? ___Yes ___ No
Do you use tobacco? ___Yes ___ No
Have you ever used tobacco? ___Yes ___ No
Do you use caffeine? ___Yes ___ No
Do you use recreational drugs? ___Yes ___ No
Have you ever used recreational drugs? ___Yes ___ No
Do you have children? ___Yes ___ No How many children?_____
What is your marital status?_____
What is you occupation? _____

**Family Medical History** (Please check appropriate family members)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Arthritis | __None | __Mother | __Father | __Sister(s) | __Brother(s) | __Daughter(s) | __Son(s) | __Extended Family |
| Asthma | __None | __Mother | __Father | __Sister(s) | __Brother(s) | __Daughter(s) | __Son(s) | __Extended Family |
| Cancer | __None | __Mother | __Father | __Sister(s) | __Brother(s) | __Daughter(s) | __Son(s) | __Extended Family |
| Chemical Dependency | __None | __Mother | __Father | __Sister(s) | __Brother(s) | __Daughter(s) | __Son(s) | __Extended Family |
| Diabetes | __None | __Mother | __Father | __Sister(s) | __Brother(s) | __Daughter(s) | __Son(s) | __Extended Family |
| Heart Disease | __None | __Mother | __Father | __Sister(s) | __Brother(s) | __Daughter(s) | __Son(s) | __Extended Family |
| High Blood Pressure | __None | __Mother | __Father | __Sister(s) | __Brother(s) | __Daughter(s) | __Son(s) | __Extended Family |
| Stroke | __None | __Mother | __Father | __Sister(s) | __Brother(s) | __Daughter(s) | __Son(s) | __Extended Family |
| Thyroid Disease | __None | __Mother | __Father | __Sister(s) | __Brother(s) | __Daughter(s) | __Son(s) | __Extended Family |