

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