MEDICAL HISTORY FORM

Patient Name:_____ DOB:_____

PERSONAL MEDICAL HISTORY:

Heart Disease – Do you have any personal history of the following:

Hypertension (high blood pressure)	Yes ☑	No ☐
Hyperlipidemia (high cholesterol)	Yes ☑	No ☐
Myocardial Infarction (heart attack)	Yes ☑	No ☐
Cardiac Arrest	Yes ☑	No ☐
Atrial Fibrillation	Yes ☑	No ☐

Diabetes – Do you have any personal history of the following:

Diabetes Mellitus Type I	Yes ☑	No ☐
Diabetes Mellitus Type II	Yes ☑	No ☐
Diabetes Insipidus	Yes ☑	No ☐
Gestational Diabetes (females only)	Yes ☑	No ☐

Other – Do you have any personal history of the following:

Cerebrovascular Accident (stroke)	Yes ☑	No ☐
TIA	Yes ☑	No ☐
Depression/Anxiety	Yes ☑	No ☐
Hyperthyroidism/Hypothyroidism	Yes ☑	No ☐
Acid Reflux or GERD	Yes ☑	No ☐
Migraine	Yes ☑	No ☐
Arthritis	Yes ☑	No ☐
Kidney Disease	Yes ☑	No ☐
Skin Cancer	Yes ☑	No ☐
Type_____		
Cancer	Yes ☑	No ☐

If yes, please provide details/type:_____
_____

Prostate Problems (male only)	Yes ☑	No ☐

Infectious Disease – Do you have any personal history of the following:

AIDS/HIV	Yes☐	No☐
Hepatitis B	Yes☐	No☐
Hepatitis C	Yes☐	No☐
C. Diff	Yes☐	No☐
Herpes Simplex I (cold sores)	Yes☐	No☐
Sexually Transmitted Diseases (STD's)	Yes☐	No☐

Please list any other current or past medical conditions:

_____

_____

_____

FAMILY MEDICAL HISTORY:

Heart Disease	Relative(s)_____
Diabetes Type I/Type II	Relative(s)_____
Depression/Anxiety	Relative(s)_____
Mental Illness	Relative(s)_____
Cancer	Relative(s)_____

Please list any other pertinent FAMILY medical history and relation to you:

_____

_____

_____

ALLERGIES – Please list ALL medication, food, and environmental allergies below with reaction:

_____

_____

Surgical History – Please list ALL surgical history below:

_____

_____

Medications – Please list ALL medications, including over the counter and prescription medications, as well as vitamins and supplements. If you are taking prescription medications, please list the dosage, frequency and any other instructions:

_____

_____

_____

Other Pertinent Medical Information – Please fill out completely to the best of your ability:

Date of last annual physical: _____

Date of last eye exam: _____

Date of last dental exam: _____

Date of last tetanus injection: _____

Have you had any recent blood work done? If so, when and where? Please provide copies of results if you have:

_____

_____

Do you have a pacemaker or internal defibrillator? _____

Do you use tobacco or chew?_____

Do you use alcohol? How often? _____

Do you use any illegal drugs? _____

When was your last prostate exam (males only)?_____

When was your last pap smear/pelvic exam (females only)?_____

When was your last menstrual cycle (females only)?_____

Have you ever had a mammogram? If so, date and location: _____

Do you see any specialists? If so, please list their name(s) and specialty:

_____

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