Medical History Form

Current Medical Problems:
____
____
____
____
____
____
____
____

Do you have or have you been treated for:
__ DM
__ Heart problem
__ HTN
__ Anxiety/Depression
__ Alzheimer's/Dementia
__ Arthritis/Joint Problems
__ COPD/Breathing problems
__ Cancer
__ High Cholesterol
__ Acid Reflux

Current Height: ___ft ___in Weigh: ____lbs

What other past medical problems do you have: ____
____

In the past year have you been hospitalized? if so when and for what: ____________________________
____

What surgeries have you had?

__Tonsillectomy	__Tubal/vasectomy	Other:_________________________________
__Appendectomy	__Hysterectomy	_________________________________
__Gall Bladder	__Joint/Orthopedic	_________________________________
__C-section	__Heart	_________________________________

Are you Allergic to any medication?: ____

Please Provide a complete list of medications, including over the counter medications and vitamins (use a separate list if needed)____
____

Primary pharmacy, do you use more than one, if so please list: ______________________________
____

Do you have any hearing problems: ___Do you have hearing aids?___
Do you where glasses? ____ or Contacts. Reading glasses only? ____

Vaccines: do you have a current…
__Flu Vaccine
__Pneumonia Vaccine
__Shingles Vaccine

Do you have any false teeth or dentures? ___________

Age and health of your:

Mother: _______________Father: _______________

Do you have a Family Medical History of:
Diabetes: M F S C Heart Disease: M F S C
High blood pressure: M F S C Stroke: M F S C
Cancer: M F S C Asthma: M F S C
Seizures: M F S C Bleeding problems: M F S C
Mental Disease: M F S C

Screenings:
Last Mammogram Year:______
Last Pap smear Year:______
Last PSA tested Year:______
Last colonoscopy Year:______

M- Mother, F-Father, S-Sibling, C-Child

Medical History Form Continued

Where were you born?____

Highest level of education?____

Occupation:____
Are you still working or retired?____

Are you Married Widow Divorced Single ?

Do you have Children?_____ How many?_________________________________

Any Grandchildren?____ How Many?___________________________________

Who resides in your home:____

Hobbies:____

Do you exercise regularly? Y or N

Do you smoke?	Do you Drink Alcohol?	Do you use recreational or illicit drugs?
Y N Quit	Occ, Socially, Often, Heavily	N Y What_________

Check any symptoms that you are having

___ Wt Loss ___Fevers ___Chills ___Night sweats

___Hair loss ___Skin changes ___Rashes ___New lumps/moles

___Headaches ___Blurred vision ___Dizziness ___Hearing loss ___vision changes

___Runny nose ___Seasonal Allergies ___Nose bleeds

___Bleeding gum ___Dental pain ___Sore Throat ___Swollen glands

___Shortness of breath ___Cough ___Breathing problems

___Hypertension ___Heart murmur ___Chest pains ___Palpitations ___Abnormal EKG

___Changes in appetite ___Nausea ___Vomiting ___Reflux ___Trouble swallowing

___Bowel troubles ___Constipation ___Hemorrhoids ___Abdominal pains ___Hepatitis

___Urinary Frequency ___Pain with urination ___Blood in your urine ___Incontinence

___Leg edema ___Blood Clots ___weakness ___Joint pain

___Numbness ___Nerve pain ___Tremors ___Fainting ___Seizures

___Anemia ___Bleeding problems ___Hot or Cold intolerance ___Thyroid problems

___Mood problems ___Anxiety ___Depression ___Memory loss ___Dementia

___Behavioral problems ___Substance Abuse