Patient Medical History Form

Patient Name: _____ **Date of Birth**: _____/_____/_____

To help the doctor serve you better, please complete the information below. Thank you!

Allergies: □ No known Allergies (If yes, please list all Drug, Food, and Environmental Allergies below:)

_____

_____

Medications: Preferred Pharmacy: _____ Location: _____

Please list all current Over the Counter and Prescribed Medications with their corresponding dosages: (if known)

NAME OF MEDICATION	STRENGTH	HOW OFTEN?	MONTH/YR STARTED

Personal Medical History: Did you in the **Past**, or do you **Currently** have problems with any of the following?
(Please check all that apply to YOU)

CONDITION	PAST	CURRENT	DATE/ AGE ONSET:	DATE/AGE RESOLVED:
ABDOMINAL PAIN- CHRONIC				
AGITATION				
ALCOHOL ABUSE/ ADDICTION				
ALLERGIES				
ANEMIA				
ARTHRITIS				
ASTHMA				
BACK PAIN-RECURRENT				
BLEEDING EASILY				
BLOOD IN URINE/HEMATURIA				
BLOODY OR TARRY STOOLS				
BONE FRACTURE OR JOIN INJURY				
CANCER				
CATARACTS				
CHEST PAIN				
CHICKEN POX				
CHRONIC COUGH				
CHRONIC FATIGUE				
COLD NUMB FEET				
COLITIS				
CONSTIPATION				
CROHN'S DISEASE				
DECREASE IN FLOW OR FORCE OF URINE				
DECREASED HEARING				
DEPRESSION/MOODINESS				
DIABETES				

Patient Medical History Form *continued…*

Patient Name: _____ **Date of Birth**: _____/_____/_____

CONDITION	PAST	CURRENT	DATE/ AGE ONSET:	DATE/AGE RESOLVED:
DIARRHEA				
DIFFICULTY SWALLOWING				
DIVERTICULOSIS				
DIZZY SPELLS				
DOUBLE OR BLURRED VISION				
DRUG ABUSE/ADDICTION				
EAR INFECTIONS- FREQUENT				
ECZEMA				
EPILEPSY				
EYE PAIN				
FAILING VISION				
FAINTING SPELLS				
FEELINGS OF WORTHLESSNESS				
FOOT PAIN				
GALL BLADDER TROUBLE				
GERMAN MEASLES				
GLAUCOMA				
GOUT				
HEADACHES/MIGRAINE				
HEART DISEASE				
HEART MURMUR				
HEARTBURN				
HEMORRHOIDS				
HERNIA				
HERPES				
HIGH BLOOD PRESSURE				
HIGH CHOLESTEROL				
HOARSENESS- PROLONGED				
IRREGULAR PULSE/HEART PALPITATIONS				
JAUNDICE/ HEPATITIS				
KIDNEY STONES				
LEG PAIN- WHEN WALKING				
LOSS OF APPETITE – RECENT				
LOSS OF CONTROL OF BLADDER-URINATION				
MEASLES				
MEMORY LOSS				
MENTAL ILLNESS				
MUMPS				
NERVOUSNESS				
NOSE BLEED- FREQUENT OR RECURRENT				
NUMBNESS-TINGLING SENSATIONS				
OSTEOPOROSIS				
OTHER:				
PAINFUL URINATION				
PEPTIC ULCER				
PERSISTENT NAUSEA/ VOMITING				

Patient Medical History Form *continued…*

Patient Name: _____ **Date of Birth**: _____/_____/_____

CONDITION	PAST	CURRENT	DATE/ AGE ONSET:	DATE/AGE RESOLVED:
PHOBIAS				
PNEUMONIA/ PLEURISY				
POLIO				
PSORIASIS				
RASHES/HIVES				
RECENT HAIR LOSS				
RECENT UNEXPECTED WEIGHT CHANGE				
RHEUMATIC FEVER				
RINGING IN EAR				
SCARLET FEVER				
SEVERE DEPRESSION				
SHORTNESS OF BREATH WHILE ACTIVE				
SHORTNESS OF BREATH WHILE AT REST				
SINUS TROUBLE				
SLEEPING DIFFICULTY				
SORE THROAT- FREQUENT				
STROKE				
SUICIDAL IDEATIONS				
SWOLLEN ANKLES				
THYROID DISEASE				
TREMOR				
TROUBLE WITH CONCENTRATION				
TUBERCULOSIS				
URETHRAL DISCHARGE				
URINATION MORE THAN TWICE AT NIGHT				
URINE/BLADDER INFECTIONS – FREQUENT				
VARICOSE VEINS/PHLEBITIS				
VENEREAL DISEASE				
WHEEZING				
OTHER:				

Procedures and Surgeries: □ NONE (If yes, please list all Procedures/Surgeries and indicate when. Ex.: Tonsillectomy-2005

Procedure/ Surgery:	When:

Last Colonoscopy	DATE	PLACE/NAME OF DOCTOR
Last Mammogram		
Last Pap Smear		
Last Eye Exam		
Last Bone Density Scan		

***Patient Medical History Form** continued…*

Family History: Does any of the below condition apply to your relative(s)? If so, please mark (x) accordingly.

TYPE	MOTHER	FATHER	SISTER	BROTHER	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcohol Abuse								
Allergies								
Anemia								
Arthritis								
Asthma								
Bleeding Easily								
Cancer: 1.								
2.								
3.								
4.								
Diabetes								
Epilepsy								
Glaucoma								
Headache/ Migraine								
Heart Disease								
High Blood Pressure								
High Cholesterol								
Mental Illness								
Osteoporosis								
Severe Depression								
Stroke								
Thyroid Disease								
Other:								

Social History:

ALCOHOL USE:	TYPE (PLEASE CIRCLE)	AMOUNT AND FREQUENCY
□ CURRENT □ PAST □ NEVER □ QUIT SINCE: _____	Beer, Wine, Liquor Other: _____	
TOBACCO USE:	TYPE (PLEASE CIRCLE)	AMOUNT AND FREQUENCY
□ CURRENT □ PAST □ NEVER □ QUIT SINCE: _____	Cigarettes, Cigars, Snuffs, E-Cigarette Other: _____	
SUBSTANCE/DRUG USE:	TYPE (PLEASE CIRCLE)	AMOUNT AND FREQUENCY
□ CURRENT □ PAST □ NEVER □ QUIT SINCE: _____	Marijuana, Cocaine, Heroin, Opioids Other: _____	

_____

Patient Medical History Form *continued…*

Pregnancies:

Please complete below for all pregnancies including abortions, miscarriages, etc.

DATE/ TIME	NUMBER OF WKS. PREGNANT	PREGNANCY/ DELIVERY OUTCOME	LENGTH OF LABOR	SEX OF THE BABY	WEIGHT	ANESTHESIA	HOSPITAL
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

DO YOU HAVE A LIVING WILL or ADVANCED DIRECTIVE? This is to indicate your wishes in the event of clinical changes to your health.	□ YES □ NO

Other Specialist(s) Seen Currently

TYPE OF SPECIALTY	REASON TO SEE SPECIALIST	PHYSICIAN/PRACTICE NAME	PHONE #

I certify that the information contained herein is complete and accurate to the best of my knowledge.

_____

Patient Signature Date

Patient Medical History Form *continued…*

Patient Name: _____ **Date of Birth**: _____/_____/_____

Employment and Education

Status:	**Work Hazards:**	**Activity Level:**
□ Employed □ Retired □ Disability □ Student □ Part-Time □ Unemployed Other: _____ **Do you operate any hazardous equipment?** Y / N	□ Hazardous Materials □ Repetitive Motion □ Heavy Lifting/Twisting □ Shift/Night Work □ Loud Noises □ Vibration □ Medical/Clinical Work Other: _____	□ Desk/Office □ Moderate Physical Work □ Occasional Physical Work □ Heavy Physical Work Other: _____

Previous Employment/School:	**Highest Education:**	**School Concerns:**
_____ _____ _____ _____ Additional Information: _____ _____	□ None □ Bachelor's Degree □ Elementary School □ Master's Degree □ Adv. Graduate or Ph.D. □ High School/GED □ Middle School □ Some College	□ Learning □ Health □ Social □ Cultural □ Communication □ Other: Additional Information: _____ _____

Home and Environment

Marital Status:	**Lives With:**	**Living Situation:**
□ Single □ Separate □ Married □ Never Married □ Married (Living Together) □ Divorce □ Widowed □ Annulled □ Life Partner Other:_____	□ Self □ Mother □ Children □ Roomate(s)/ Friend(s) □ Family □ Siblings □ Father □ Significant Other □ Foster Family □ Spouse □ Grandparents Other: _____	□ Home/Independent □ Home with Assistance Physical Work □ Homeless/Shelter Other: _____ **Number of Children:** _____

Environment Screening

Have you experience any abuse in your house hold?	**Do you feel unsafe at home?** Y / N **Do you have a safe place to go?** Y / N **Do you have Family/Friends available to help?** Y / N	**Have you notified any Agencies about your abuse?** Y / N **Agency(s)/Others Notified:** _____ _____

Patient Name: _____ **Date of Birth**: _____/_____/_____

Nutrition and Health

Briefly write your routine diet:	Type of Diet:	OTHER:
	□ Regular □ Calorie Restricted □ Diabetic □ Dysphagia Diet □ Ketogenic Diet □ Kosher □ Low Carbohydrate □ Low Fat □ Low Sodium □ Renal □ Total Parenteral Nutrition □ Vegetarian Other: _____	Diet Restrictions: _____ _____ Caffeine intake amount: _____ **Do you want to lose weight?** Y / N

Vitamins/Alternative Health	Eating Disorders:	OTHER:
Vitamins/Supplements: _____ _____ Uses Alternative Healthcare: _____ _____	□ Bulimia □ Anorexia Nervosa □ Overeating Other: _____ _____ _____	**Sleeping concerns?** Y / N _____ _____ **Feeling highly Stressed?** Y / N _____ _____

Exercise and Physical Activity

Exercises	Exercise Type:	Self Assessment
How many times per week? □ Never □ 1-2 times □ 3-4 times □ 5-6 times □ Daily Other: _____	**Duration (Average # of minutes):** _____ □ Aerobics □ Bicycling □ Organized Team Sports □ PE Class □ Running □ Swimming □ Walking □ Weight Lifting □ Yoga Other: _____	□ Poor Condition □ Fair Condition □ Good Condition □ Excellent Condition Other/Comment: _____ _____ _____

Patient Medical History Form *continued…*

Patient Name: _____ **Date of Birth**: _____/_____/_____

Sexual Activity

Activity	Orientation:	Contraceptive Use Details
Are you Sexually Active? Y / N **When were you first active?** **Age:_____** **Number of lifetime partners**: _____ **Number of current partners**: _____	**Self describe orientation:** □ Heterosexual □ Bisexual □ Homosexual □ Transgender Other: _____ **Do you use condoms?** Y / N	□ Abstinence □ Condoms □ Birth Control Implant □ Intrauterine Device □ Birth Control PATCH □ Vaginal Ring □ Birth Control PILL □ None □ Birth Control SHOT Other Contraceptive Use/Comment: _____

History of Abuse	Other Related Concerns:
Have you ever been sexually abused? Y / N Comment: _____ _____ _____	