

Today's Date: _____



PATIENT MEDICAL HISTORY FORM

Patient Name: (Last)	(First)	(MI)	DOB: / /
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PATIENT HISTORY

INDICATE ANY CONDITION YOU ARE CURRENTLY BEING TREATED FOR OR HAVE HAD IN THE PAST:

- | | | |
|--|--|---|
| <input type="checkbox"/> Head/brain injuries or illnesses (e.g., concussion)
<input type="checkbox"/> Seizures, epilepsy
<input type="checkbox"/> Eye problems (except glasses or contacts)
<input type="checkbox"/> Anemia
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Ear and or hearing problems
<input type="checkbox"/> Heart disease, heart attack, bypass, or other heart problems
Pacemaker, stents, implantable devices, or other heart Procedure
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Low blood pressure | <input type="checkbox"/> High cholesterol
<input type="checkbox"/> Chronic (long-term) cough, shortness of breath or breathing Problems
<input type="checkbox"/> Lung disease (e.g., asthma, COPD)
<input type="checkbox"/> Kidney problems, Kidney stones, any pain with urination
<input type="checkbox"/> Stomach, Liver, Gastric Reflux, or digestive problems
<input type="checkbox"/> Diabetes or blood sugar problems
<input type="checkbox"/> Anxiety, depression, nervousness, or other mental health problems
<input type="checkbox"/> Fainting or passing out
<input type="checkbox"/> Dizziness, headaches, numbness, tingling, or memory loss | <input type="checkbox"/> Unexplained weight loss
<input type="checkbox"/> Stroke, mini stroke (TIA), paralysis, or weakness
<input type="checkbox"/> Neck or back problems
<input type="checkbox"/> Bone, muscle, joint or nerve problems
<input type="checkbox"/> Blood clots or bleeding
<input type="checkbox"/> Cancer: (Type) _____
<input type="checkbox"/> Chronic (long term) infection or other chronic diseases
<input type="checkbox"/> Sleep disorders, pauses in breathing while asleep, loud snoring |
|--|--|---|

ALLERGIES: (Include medication, food, latex, and environmental allergies)			No known allergies <input type="checkbox"/>
Allergy to:			
Severity:	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Reaction:			

CURRENT MEDICATIONS				No current medications <input type="checkbox"/>
1.	2.	3.	4.	
5.	6.	7.	8.	
9.	10.	11.	12.	

PROCEDURES/SURGERIES			No procedures or surgeries <input type="checkbox"/>
Surgery/Procedure #1	Approximate Date:	Surgery/Procedure #3	Approximate Date:
Surgery/Procedure #2	Approximate Date:	Surgery/Procedure #4	Approximate Date:

PREVENTATIVE SCREENINGS		Not applicable <input type="checkbox"/>
For Male patients:		
Have you had a colonoscopy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date:	
Have you had a prostate screening? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date:	
For Female patients:		
Have you had a colonoscopy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date:	
Have you had a mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date:	
When was your most recent menstrual cycle?	date:	
When was your most recent PAP/Pelvic Exam?	date:	

FAMILY HISTORY

N/A

Mother:	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/>
Father:	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/>
Sister:	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/>
Brother:	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/>
Grandmother (M):	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/>
Grandmother(P):	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/>
Grandfather(M):	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/>
Grandfather (P):	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/>

OTHER HEALTH ISSUES

Do you drink caffeine? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Soda	# of cups/cans per day? _____
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor	How many drinks per week? _____
Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> cigarettes-pks/day _____ <input type="checkbox"/> chew-#/day _____ <input type="checkbox"/> pipe/cigars-#/day _____	
Marijuana/recreational drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, _____ per day, _____ # years of use.	
Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mild exercise (climb stairs, walk 3 blocks) <input type="checkbox"/> Regular exercise (30 minutes a day)	

IMMUNIZATIONS (Vaccines)

Influenza (18 years of age and older) <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date: _____
Pneumococcal (65 years of age and older) <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date: _____
Tetanus? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date: _____
Covid 19? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date: _____
Shingles? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date: _____
Hepatitis B series? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date: _____
MMR? (Measles,Mumps,Rubella) <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date: _____
Have you even had a blood transfusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No