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Please take a moment to fill out this medical history form so that your practitioner can get better acquainted with your medical history. We realize that not all of the questions may pertain to you, but please answer all questions that apply. Thank you.

Patient's Full Name: _____ Date of Birth: _____

Today's Date: _____ Height: _____Weight: _____ Blood Type: ☐ A ☐ B ☐ AB ☐ O+ ☐- O

Primary Care Doctor: _____ Referring Doctor: _____

Reason for Visit: _____

Preferred Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone Number: _____ Pharmacy Fax Number: _____

Allergies: (List all medications, food and environmental)

_____

_____

Medications: (List all current medications including vitamins & supplements)

Date started	*Medication & Dose*	*Directions*	*Reason for Taking*	*Prescribed by*

Past Medical History: (Please check all that apply)

☐ Attention Deficit Disorder	☐ Dizziness/Vertigo	☐ Headache	☐ Leukemia
☐ Anemia	☐ Depression	☐ Herpes	☐ Migraine Headache
☐ Asthma	☐ Easy Bleeding	☐ HIV Infection	☐ Osteoporosis
☐ Alcohol Disorder	☐ Eczema	☐ Heart Disease	☐ Pneumonia
☐ Bronchitis	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatoid Arthritis
☐ Back Problems	☐ Esophageal Reflux	☐ Hodgkin's Disease	☐ Seizure Disorder
☐ Cancer	☐ Fatigue	☐ Insomnia	☐ Sleep Apnea
☐ Concussion	☐ Gastrointestinal Disorder	☐ Lupus	☐ Stroke Syndrome
☐ Diabetes Mellitus	☐ Glaucoma	☐ Lyme Disease	☐ Thyroid Disorder

Please list any other past medical history:

_____

_____

Past Surgical History: (Please check all that apply and include the date)

Surgery	*Date*	*Surgery*	*Date*	*Surgery*	*Date*
☐ Appendectomy		☐ Hernia Repair		☐ Shoulder Surgery	
☐ Back Surgery		☐ Hysterectomy		☐ Sinus Surgery	
☐ Breast Surgery		☐ Hip Surgery		☐ Tonsillectomy	
☐ Cataract Surgery		☐ Knee Surgery		☐ Thyroid Surgery	
☐ C-Section		☐ Laparoscopy		☐ Vasectomy	
☐ Colonoscopy		☐ Pacemaker Placement		☐ Wisdom Teeth	
☐ Cosmetic Surgery		☐ Prostate Surgery		☐ Other: _____	

Family History: (Please check all that apply)

	Father	Mother	Brother	Sister	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Alcoholism								
Asthma								
Bleeding disorder								
Cancer								
Deceased								
Depression								
Diabetes								
Drug Abuse								
Epilepsy								
Heart Disease								
High Blood Pressure								
High Cholesterol								
Migraines								
Stroke								
Suicide								
Thyroid Problems								

Please list any other family medical history:

_____

_____

Prevention Information:

	Yes	*No*		*Yes*	*No*
Do you use seat belts?	☐	☐	Do you have a living will?	☐	☐
Do you have smoke detectors in your home?	☐	☐	Do you practice a healthy diet?	☐	☐
Do you have a loaded firearm in your home? If yes, how is it stored?	☐	☐			
Do you use sunscreen?	☐	☐			

Please list any vaccine history:

_____

_____

Social/Lifestyle History:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

If married, spouse's name: _____

Children(s) names and age(s): _____

What is your occupation: _____

What are your hobbies: _____

Do you exercise regularly: _____

Who lives at home with you: _____

Where were you born and raised: _____

How long have you been in this area: _____

Do you drive an automobile: _____Do you ride a motorcycle/bicycle: _____

Do you wear a helmet: _____

Do you currently smoke or use nicotine products: _____ If yes, for how many years: _____

Are you a former smoker: _____ If yes, when did you quit: _____

Cigarettes (# Packs/day): _____ Cigars: _____ Pipe: _____ Chew Tobacco: _____

Have you ever used recreational drugs: _____ If yes, when was the last time: _____

What kind did you use: _____

Do you take over-the-counter medication such as aspirin, antacids, vitamins, herbal products: _____

If yes, which ones and how often: _____

Do you take something to help you sleep: _____ If yes, what and how often: _____

Do you restrict your diet in any way: _____ If yes, how: _____

Do you drink alcohol: ☐ Never ☐ Occasionally ☐ Daily

If yes, how many days per week do you drink alcohol: _____

On a typical day when you drink, how many drinks do you have: _____

Do you drink caffeine: _____ If yes, how much: _____

Ever worked with chemicals, paints, asbestos, or any hazardous material?: _____

If yes, what kind: _____

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Review of Symptoms

Patient's Full Name: _____ Date of Birth: _____Today's Date: _____

Please check all that apply.

☐ Male ☐ Female Medication allergies: ☐ Yes ☐ No

Please check any symptoms you are experiencing today.

Systemic Symptoms	☐ fatigue ☐ fever/chills ☐ weight change
Head Related	☐ headache ☐ facial pain
Eye	☐ trouble with vision ☐ pain ☐ redness ☐ light sensitivity
Ear-Nose-Throat-Mouth	☐ earache ☐ pressure ☐ ringing ☐ TMJ ☐ runny nose ☐ nose bleeds ☐ post nasal drip ☐ sneezing ☐ snoring ☐ sore throat ☐ itchy throat ☐ hoarseness ☐ mouth sores ☐ dryness ☐ trouble swallowing
Neck	☐ swollen glands ☐ pain ☐ muscle tightness
Respiratory	☐ cough ☐ wheezing ☐ shortness of breath
Cardiovascular	☐ chest pain ☐ palpitations ☐ irregular heart rate ☐ edema ☐ fast heart rate
Gastrointestinal	☐ abdominal pain ☐ heart burn ☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation ☐ blood in stool ☐ change of bowel habits
Urinary	☐ pain ☐ frequency ☐ blood in urine
Skin	☐ rash ☐ lesions ☐ abnormal hair loss
Musculoskeletal	☐ joint pain ☐ back pain ☐ muscle pain ☐ restless legs
Neurological	☐ fainting ☐ numbness ☐ dizziness
Psychological	☐ insomnia ☐ depression ☐ anxious ☐ irritable ☐ generally not having fun in life
Male	☐ slow urine flow ☐ low libido ☐ erectile dysfunction
Female	☐ pelvic pain ☐ PMS ☐ vaginal discharge ☐ abnormal bleeding Date of last period: _____ Date of last pap: _____ Period last _____ days Period comes every _____days # of pregnancies _____ # of births _____ Current method of birth control _____
Date of last tetanus shot	

Other additional comments:

_____

_____

Print Reset

Updated Jan. 2019