



Patient Medical History Information

Name _____

Date _____

Reason for today's visit _____

History of present illness _____

Medication Allergies _____

Current Medications (please list all current medications, inhaler, over the counter meds, vitamins and herbal supplements) _____

Other Allergies (List) _____

Surgeries and Hospital stays _____

Patient Social History Information

Do you smoke? _____ If yes, how much per day? _____ How many years? _____

Have you ever smoked? _____ Quit date _____

Do you drink alcohol? _____ If yes, how often? _____ How much? _____

Do you take illicit drugs (street drugs)? _____ If yes, which drug(s)? _____

Do you drink caffeinated beverages? _____ If yes, how often? _____ How much? _____

Describe your eating habits _____

Describe your exercise routine _____

What is your sexual preference? _____

What is your highest education level? _____

What are your hobbies? _____



Patient's Name (page 2 of Medical History) _____

Family History: Answer the following questions about your family's health (your personal history is below):

Diabetes Yes No If yes, who? _____ High Blood Pressure Yes No If yes, who? _____
Asthma Yes No If yes, who? _____ High Cholesterol Yes No If yes, who? _____
Heart Issues Yes No If yes, who? _____ Heart Attack Yes No If yes, who? _____
Stroke Yes No If yes, who? _____ Depression/Anxiety Yes No If yes, who? _____
Cancer Yes No If yes, who and what type? _____

Medical History: Have you ever been diagnosed with or are currently having any of the following symptoms? Please circle all that apply, and note the date this was an issue for you.

HEENT:

Headache
Ear Problems
Nose/sinus Problems
Throat Problems

Musculoskeletal:

Back Problems
Joint Pain
Arthritis
Broken Bones
Osteoporosis

Endocrine:

Diabetes
Thyroid Problems
Tired/sluggish
Excessive Thirst

Neurologic:

Seizures/epilepsy
Stroke
Loss of Strength
Loss of Sensation
Numbness/tingling
Multiple Sclerosis

Respiratory:

Asthma
COPD
Emphysema
Bronchitis
Pneumonia
Pulmonary Embolism

Gastrointestinal:

Abdominal Pain
Constipation
Diarrhea
Colitis
Diverticulitis
Heartburn/reflux
Ulcers
Hemorrhoids
Change in Bowel Habits

Genitourinary/GYN:

Bladder Infections
Kidney Stones
Prostate Infections
Ovary Problems
Uterine Problems
Abnormal Pap Smear
Breast Lump

Blood/Immune:

Anemia
Blood Clot
Jaundice
Lupus
Liver Disease

Cardiac:

Chest Pain (Angina)
Heart Attack
High Blood Pressure
High Cholesterol
Heart Racing
Palpitations
Heart Failure
Pacemaker
Heart Valve
Rheumatic Fever

Skin:

Hives
Eczema
Psoriasis
Allergic Rash

Psychologic:

Anxiety
Depression
Bipolar Disease
Panic Attacks

Communicable Diseases: Have you ever had hepatitis? Yes No If yes, what type? A B C

Sexually Transmitted Diseases: Yes No If yes, what disease(s)? _____

Cancer: Have you ever been diagnosed with cancer? Yes No If yes, what type? _____

What treatment did you have? _____

Date of diagnosis: _____

Signature: _____ Date: _____