

MEDICAL HISTORY

NAME: _____ Birth Date: _____ Date: _____

1. Why are you seeing the Doctor today? _____ 2. How long have you had this problem? _____

Medications: LEAVE BLANK IF YOU HAVE A MEDICATION LIST		
<i>Please list your prescribed and over-the-counter drugs, such as vitamins, aspirin, allergy meds, etc.</i>		
Name the Drug	Strength	Frequency Taken

Allergies to Medications	No	Yes, if so, please explain below:
Name of drug	Reaction you had	

Please list current pharmacy		
Name	Phone Number	Address

Please answer all of the following questions related to your current or past medical history.

<u>Circle</u>			<u>Describe your Problem</u>
NO	YES	Headaches	_____
NO	YES	Eyes/Vision	_____
NO	YES	Do you wear contact/glasses?	_____
_____		If seeing Ophthalmologist, when was last Exam?	_____
NO	YES	Ears, Nose, Throat	_____
NO	YES	Lungs, Breathing	_____
NO	YES	Heart Problems	_____
NO	YES	Digestion	_____
NO	YES	Bowel Problem	_____
NO	YES	Bladder Problem	_____
NO	YES	Diabetes	_____
NO	YES	High Blood Pressure	_____
NO	YES	Bleeding Problems	_____
NO	YES	Balance Problem	_____
NO	YES	Numbness/Tingling	_____
NO	YES	Blackout/Fainting	_____
NO	YES	Anxiety/Depression	_____
NO	YES	AIDS/HIV	_____
NO	YES	Cancer	_____
NO	YES	Arthritis	_____
NO	YES	Polio	_____
NO	YES	TB	_____
NO	YES	Epilepsy (Seizures)	_____

PAST MEDICAL / HOSPITALIZATION

Hospitalizations: (Medical & Surgical) Year Any Complications?

Family Medical History

Family Member	Age Now or at Death	Cause of Death	Any Health Problems if alive
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sibling 1 M F			
Sibling 2 M F			
Sibling 3 M F			

Social History

Employed (occupation) _____ Work at home Student
Do you currently smoke? Yes No
If yes, how many packs per day? _____ for years _____ years
If no, did you ever smoke and when did you quit? _____
Do you drink alcoholic beverages? Yes No If yes, how often? Daily 1-2 times/week 1-2 times/month
Do you or have you ever used recreational/illicit drugs? Yes No
Do you have any hearing impairments? Yes No Do you wear a hearing aid? Yes No
Do you have dentures? Yes No
Do you have children? Yes No # _____
Do you live alone? Yes No
Are you on a special Diet? Yes No Describe _____

Females Only - Please Complete

Menstrual Flow (please check all that apply): Regular Irregular Pain/Cramps
Days of Flow: _____ Length of Cycle: _____ Date (1st day) of last period: _____
If you no longer have menstrual cycle, please list year menses stopped: _____
Number of: Pregnancies _____ Live Births _____ Miscarriages _____ Abortions _____
Birth Control Method: _____ If Birth Control Pill, list name of Pill _____