MEDICAL HISTORY FORM

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

REASON FOR VISIT: _____

NAME OF EMERGENCY CONTACT: _____ **Relationship** _____ **Phone** _____

FAMILY HISTORY

Has any blood relative ever had the following? (Please indicate by circling the condition(s) w/ brief description.)

Breast Cancer	High blood pressure	Kidney Disease
Melanoma	Heart Disease	Depression
Other skin cancer	Stroke	Diabetes

PAST MEDICAL HISTORY

Have you ever had the following: (Please indicate by circling the condition(s) w/ brief description.)

Heart Disease	Cancer	Stomach Ulcer
Arthritis	Glaucoma	Kidney Disease
Rheumatic Fever	Asthma	Thyroid Disease
Anemia	AIDS or HIV positive	Stroke
Tuberculosis	Abnormal Bleeding	Diabetes
Bladder infections	Hepatitis	Emphysema
High Blood Pressure	Epilepsy	Other lung problems
Heart Murmur	Abnormal liver	Other

NAME OF PRIMARY CARE PHYSICIAN: _____

LIST ANY PREVIOUS SURGERIES

Year	Procedure

ALLERGIES TO MEDICATIONS: (please list medication and reaction): _____

List all medications (including dosage) you are taking including non-prescription drugs, vitamins or herbals: _____

Are you currently taking Aspirin ☐ No ☐ Yes Reason: _____ Are you taking Coumadin ☐ No ☐ Yes

REVIEW OF SYSTEMS (to be reviewed with the physician and/or assistant)

Do you have now or have you had within the past year: (Please indicate by circling the condition(s).

Weight Change	Swollen Feet/Ankles	Seizures
Dry Eyes	Skin Rash	Joint/Muscle Pain
Chronic Cough	Chronic Diarrhea	Jaundice
Swollen Lymph Nodes	Chest Pain	Easy Bleeding
Rapid Heart Beat	Depression	Easy Bruising
		All Others Negative

FOR WOMEN ONLY

Currently pregnant ☐ No ☐ Yes Are you currently breast feeding ☐ No ☐ Yes Date of last mammogram _____

SOCIAL HABITS

	No	Yes	When Started	When Stopped	Amount
Tobacco Use					Packs per day
Coffee					Cups per day
Alcohol			Liquor per day	Wine per day	Beer per day
Recreational Drugs					

I verify that the above information is true and accurate to the best of my knowledge.

_____ _____

Patient Signature (or parent if patient is a minor) Date

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