Medical History Form

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

Primary Care Physician: _____ Referring Physician: _____

Personal Medical History: Have you ever been diagnosed with the following? (Please check)

- ☐ Cancer
- ☐ Heart Disease/CHF
- ☐ High Blood Pressure
- ☐ Blood Disorders
- ☐ Anemia
- ☐ Blood Clots
- ☐ Neurological disease
- ☐ Epilepsy/seizures
- ☐ Stroke
- ☐ Migraines
- ☐ Lung Disease
- ☐ Pneumonia
- ☐ Asthma
- ☐ Asbestos Exposure
- ☐ Tuberculosis
- ☐ Emphysema/COPD
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Pancreatic disease
- ☐ Inflammatory Bowel Disease
- ☐ Gallbladder disease
- ☐ Kidney Disease
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Alcohol/Drug dependence
- ☐ Mental Health Issues
- ☐ Rheumatoid Arthritis
- ☐ Lupus/autoimmune
- ☐ Multiple Sclerosis
- ☐ HIV/AIDS
- ☐ Osteoarthritis
- ☐ Skin ulcers

Other: _____

Surgical History: List operations you have had and the reason for surgery. Please give approximate date and list in chronological order, if possible, including tonsils, C-Sections, etc.

1. _____
2. _____
3. _____
4. _____

Hospitalizations, Serious illness, and injuries: Please give approximate date and list in chronological order if possible.

1. _____
2. _____
3. _____
4. _____

Have you had a blood transfusion? ☐Yes ☐No

Family History:

Relationship	Please circle	Age	If Deceased: Age at Death and Cause of Death	Significant Medical History
Father	Alive Deceased			
Mother	Alive Deceased			
Sibling 1:	Alive Deceased			
Sibling 2:	Alive Deceased			
Sibling 3:	Alive Deceased			
Sibling 4:	Alive Deceased			

Has any of your extended family ever had any of the following (including cousins, grandparents, aunts/uncles):

Relationship	Age at onset	History of Cancer (If yes, indicate type)	History of Blood Clots (If yes, where)	History of Excessive Bleeding (if yes, where)
Maternal Mother				
Maternal Father				
Paternal Mother				
Paternal Father				
Aunt(s) / Uncle(s)				
Cousin(s)				
Other				

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

Do you have an advance directive for healthcare decisions? ☐Yes ☐No

Social History:

Do you use nicotine? ☐Yes ☐No How much/how long: _____ Quit/When: _____
What type? ☐Cigarettes ☐Cigars ☐Chew
Do you drink alcohol? ☐Yes ☐No How much/how long: _____ Quit/When: _____
Have you used drugs? ☐Yes ☐No What type: _____Quit/When: _____
Marital Status: ☐Single ☐Married ☐Domestic Partnership ☐Divorced ☐Widowed
Living Situation: ☐ Alone ☐Roommate ☐Spouse/Partner ☐Significant Other ☐With Children ☐Parents

Immunizations: Please give date of most recent vaccination or series completion date.

Influenza: _____Pneumonia: _____ Hepatitis A: _____ Hepatitis B: _____
Shingles: _____ Tetanus: _____ HPV: _____ Meningococcal: _____

Preventative Health:

Have you ever had a colonoscopy? ☐Yes ☐No
Date/location of last colonoscopy: _____Findings:_____
Have you ever had bone density test? ☐Yes ☐No
Date/location of last test: _____ Findings: _____
Have you had a mammogram? ☐Yes ☐No
Date/location of last mammogram:_____Findings:_____

FOR WOMEN

Menstrual History:

Date of last period: _____ Age periods began: _____ Age of Menopause: _____
Date of last Pap smear: _____ Have you ever had an abnormal Pap smear? ☐Yes ☐No
Number of live births: _____ Number of pregnancies: _____
Current birth control method: _____ Are you interested in preserving your fertility? ☐Yes ☐No

Medication Allergies: List medication and reaction.

Medication	Reaction	Medication	Reaction

Medication List: List medication, dose and how often you take it. Include non-prescriptive items and supplements.

Name	Dose	Frequency	Name	Dose	Frequency