MEDICAL HISTORY FORM

Name: _____

DOB: _____ **Adopted:** □ Y □ N

Employer: _____

Occupation: _____

Current Status: □ Married □ Single □ Other
Children Names/Ages:

Please check if you currently have or have had any of the following:

□ Asthma □ Hypertension □ Depression □ Psychiatric Disorder
□ Hepatitis B □ Seizures □ Blood Clots □ Bleeding Disorder
□ Hepatitis C □ Heartburn □ Diabetes □ Heart Disease
□ Ulcers □ Hayfever □ Migraines □ Elevated Cholesterol
□ Urinating Difficulties □Thyroid Disease □ Cancer
□ Other Please specify: _____
Comments: _____

Immunizations:

Last Tetanus: _____
Last TB: _____ Positive: □ Y □ N
Hepatitis A Series: _____
Hepatitis B Series: _____
Flu: _____

Date of Last Preventative:

Colonoscopy: Year _____ Normal?: □ Y □ N
Pap: Year _____ Normal?: □ Y □ N
Mammograms: Year _____ Normal?: □ Y □ N
Dexascan: Year _____ Normal?: □ Y □ N

Medications:
List medications and dose you are currently taking.
Include vitamins and herbal supplements.
Check if no medications. □

Allergies:

Preferred Pharmacy? _____

Please mark any past surgeries and/or hospitalizations, indicate which by marking an S or H.

Back___(S/H) Sinus___(S/H) Tonsils___(S/H) Bones___(S/H)
Hernia___(S/H) Appendix___(S/H) Vasectomy___(S/H)
Gall Bladder___(S/H) Tubal Ligation___(S/H)
Hysterectomy ___(S/H) Ovaries Removed? (Y/N)
Other/Comments: _____

Family History: (Blood Relatives Only)

Father: □ Alive □ Deceased	Present Health or Cause of Death	Age?
Mother: □ Alive □ Deceased	Present Health or Cause of Death	Age?
Brothers: ___# Alive ___# Deceased	Present Health or Cause of Death	Age?
Sisters: ___# Alive ___# Deceased	Present Health or Cause of Death	Age?

□ Y □ N Tobacco _____ (packs/day)
Former Tobacco User _____ (date quit)
□ Y □ N Alcohol _____ (drinks/week)
□ Y □ N Recreational Drugs _____ (type)
□ Y □ N Exercise _____ (times/week)
Sexual Orientation:_____ (optional)
Religious Preference: _____ (optional)
Do religious beliefs impact your daily activities? □ Y □ N
Comments: _____

Please check medical problems ***immediate family members*** have or have had in the past.

Medical Complaints	Mother	Father	Siblings	Comments - **Age?**
Heart Attack	□	□	□	
Diabetes	□	□	□	
Glaucoma	□	□	□	
Cancer (list type)	□	□	□	
Osteoporosis	□	□	□	
Stroke	□	□	□	
High Blood Pressure	□	□	□	
Kidney Disease	□	□	□	
Brain Aneurysm	□	□	□	
Blood Clots	□	□	□	
Colon Polyps	□	□	□	
High Cholesterol	□	□	□	
Thyroid Disease	□	□	□	
Depression	□	□	□	

Females Only:

Current method of Birth Control: _____
Has your husband had a vasectomy? □ Y □ N

Total # of Pregnancies: _____
Live Births: _____
Miscarriages/Abortions: _____

Please initial and date any updates made:

_____ (sign/date)

_____ (sign/date)

_____ (sign/date)

_____ (sign/date)