MEDICAL HISTORY FORM

Name: _____

DOB: _____ **Adopted:** □ Y □ N

Employer: _____

Occupation: _____ **Pilot?** □ Y □ N

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

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Multiracial (*Required for vaccine administration purposes*.)

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 □ Allergies □ Migraines □ Elevated Cholesterol
□ Urinating Difficulties □Thyroid Disease □ Cancer
□ Other: _____
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 Next Due? _____
Pap: Year _____ Normal? □ Y □ N Next Due? _____
Mammograms: Year _____ Normal? □ Y □ N Next Due? _____
Dexascan: Year _____ Normal? □ Y □ N Next Due? _____

Medications:

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

Medication Allergies:

Please mark any past surgeries and/or hospitalizations.

Back___ Sinus___ Tonsils___ Bones___ Hernia___
Appendix___ Gall Bladder___ Spleen___ Vasectomy___
Tubal Ligation___ Hysterectomy ___ 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 Preference: _____ (optional)

- Gender Identity: _____ (optional)
- Preferred Pronoun: _____(optional)
- Sex Assigned at Birth: _____(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 or significant other had a vasectomy? □ Y □ N
Total # of Pregnancies (G): _____
Live Births (P): _____
Miscarriages/Abortions (Ab): _____
Pregnancy Complications: _____

Please initial and date any updates made:

_____ (sign/date)

_____ (sign/date)

_____ (sign/date)

_____ (sign/date)