

# MEDICAL HISTORY

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  Male  Female  Other

## FAMILY HISTORY *Please check all that may apply.*

	Father	Mother	Brother	Sister		Father	Mother	Brother	Sister
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____				
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Other Family History: \_\_\_\_\_

## PERSONAL HISTORY

**ILLNESSES:** *Please check all that you have been treated for.*

Alcohol Trouble	<input type="checkbox"/>	Measles	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Migraine	<input type="checkbox"/>
Back Trouble	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	Mumps	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Nervous Breakdown	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	Peptic Ulcer	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Polio	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	Sexual Diseases	<input type="checkbox"/>
German Measles	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	Thyroid Trouble	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	Tuberculosis (T.B.)	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	Urinary Tract Infection	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	Other Illnesses	<input type="checkbox"/>
Kidney Trouble	<input type="checkbox"/>	<i>If yes, please describe:</i>	_____
Lung/Respiratory Disease	<input type="checkbox"/>	_____	_____
Lung Trouble	<input type="checkbox"/>	_____	_____

## SURGERIES:

Accidents/Fractures	<input type="checkbox"/>
<i>If yes, please describe:</i>	_____
_____	_____
_____	_____
Appendectomy	<input type="checkbox"/>
Back	<input type="checkbox"/>
Breast	<input type="checkbox"/>
Cataract	<input type="checkbox"/>
Colon or Intestine	<input type="checkbox"/>
Ear Tube Replacement	<input type="checkbox"/>
Gallbladder	<input type="checkbox"/>
Hernia	<input type="checkbox"/>
Heart	<input type="checkbox"/>
Hysterectomy	<input type="checkbox"/>
Prostate	<input type="checkbox"/>
Tonsillectomy	<input type="checkbox"/>
Other Surgeries	<input type="checkbox"/>
<i>If yes, please describe:</i>	_____
_____	_____
_____	_____

## HABITS

How Much?

Tobacco	<input type="checkbox"/>	_____
Alcohol	<input type="checkbox"/>	_____
Drugs	<input type="checkbox"/>	_____
Caffeine	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	_____

## SOCIAL HISTORY

Married  Single  Widowed  Divorced  Partnered

**Date of Previous Screening Tests:** *(If applicable)*

Pap Smear	_____
Mammogram	_____
Bone Density	_____
Colonoscopy	_____

**Immunization Dates:** *(If applicable)*

Pneumococcal	_____
Flu	_____
Tetanus	_____

**Ophthalmologist Visit:** *(If applicable)*

Date: \_\_\_\_\_

Name: \_\_\_\_\_

**ALLERGIES** *Describe* \_\_\_\_\_

\_\_\_\_\_

**CURRENT MEDICATIONS** *(List by name, including over the counter)* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

