

Medical History Form

Date of Visit: _____ **OC#:** _____
Patient Full Name: _____ **Date of Birth:** _____ **Age:** _____
Who is your Primary Care Provider? _____ **Gender:** _____
Pharmacy and Phone #: _____

Medical Conditions

- None OR Write "P" for Past and "C" for Current Problem (Use other* if problem not listed.)**
- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Dementia | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sickle Cell Trait/Disease: |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> MRSA | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Clots/DVT | <input type="checkbox"/> Fracture/Broken Bone | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Breastfeeding | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cancer: type _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pregnant | |
| <input type="checkbox"/> Chronis Bronchitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pulmonary Embolism | |
| <input type="checkbox"/> COPD | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatoid Arthritis | |

List Drug Allergies and Reaction: None _____

List Current Medications (including dosage and frequency): None See Attached List

List Any Past Surgeries and Date: None See Attached List

Family History

- None Unknown/Adopted **OR** indicate if any of your blood relatives have had any of the following conditions
- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Muscle Disorders | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nerve Disorders | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer: type _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Osteoporosis | |

Social History

Tobacco Use: Non Smoker Former Smoker _____ Year Quit Current Smoker _____ # Packs/Day _____ # Years
Alcohol Use: Never Rarely Weekly Daily
Marital Status: Single Married Divorced Widowed Other
Occupation: _____

Review of Systems

Indicate if you have current problems with any of the following:

Abdominal Pain	Y	N	Difficulty Swallowing	Y	N	Nausea	Y	N
Bleed Easly	Y	N	Dizziness	Y	N	Painful Urination	Y	N
Blood in Stool	Y	N	Excessive Thirst	Y	N	Psychological Disorder	Y	N
Blood in Urine	Y	N	Headaches	Y	N	Recent Weight Change	Y	N
Bruise Easily	Y	N	Heart Palpitations	Y	N	Recurring Fever	Y	N
Chest Pain / Discomfort	Y	N	Heartburn	Y	N	Skin Problems	Y	N
Convulsions	Y	N	Hoarseness	Y	N	Sleep Disturbances	Y	N
Chronic Cough	Y	N	Increased Need to Urinate	Y	N	Temperature Intolerance	Y	N
Decreased Appetite	Y	N	Joint Problems	Y	N	Vision Problems	Y	N
Difficulty Breathing	Y	N	Loss of Hearing	Y	N	Vomiting	Y	N

For Office Use Only:							
Date Reviewed	Change? Y or N	Clinical Staff	Provider	Date Reviewed	Change? Y or N	Clinical Staff	Provider
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____