

## 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"/> Chronic 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:**  None
- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Abdominal Pain          | <input type="checkbox"/> Difficulty Swallowing     | <input type="checkbox"/> Nausea                  |
| <input type="checkbox"/> Bleeds Easily           | <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Painful Urination       |
| <input type="checkbox"/> Blood in Stool          | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Psychological Disorder  |
| <input type="checkbox"/> Blood in Urine          | <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Recent Weight Change    |
| <input type="checkbox"/> Bruise Easily           | <input type="checkbox"/> Heart Palpitations        | <input type="checkbox"/> Recurring Fever         |
| <input type="checkbox"/> Chest Pain / Discomfort | <input type="checkbox"/> Heartburn                 | <input type="checkbox"/> Skin Problems           |
| <input type="checkbox"/> Convulsions             | <input type="checkbox"/> Hoarseness                | <input type="checkbox"/> Sleep Disturbances      |
| <input type="checkbox"/> Chronic Cough           | <input type="checkbox"/> Increased Need to Urinate | <input type="checkbox"/> Temperature Intolerance |
| <input type="checkbox"/> Decreased Appetite      | <input type="checkbox"/> Joint Problems            | <input type="checkbox"/> Vision Problems         |
| <input type="checkbox"/> Difficulty Breathing    | <input type="checkbox"/> Loss of Hearing           | <input type="checkbox"/> Vomiting                |

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