MEDICAL HISTORY FORM

Name: _____

DOB: _____ **Adopted:** □ **Y** □ **N**

Employer: _____

Occupation: _____

Current **Status:** □ Married □ Single □ Other
Children Names/Year of Birth:

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

□ Asthma □ Hypertension □ Depession □ Psychiatric Problem
□ Hepatitis B □ Seizures □ Blood Clots □ Bleeding Disorder
□ Hepatitis C □ Heartburn □ Diabetes □ Heart Disease
□ Ulcers □ Hayfever □ Migraines □ Elevated Cholesterol
□ Kidney Stones □ Heart Murmer □ Cancer □ Colon Polyps
□ Urinating Difficulties □ Thyroid Disease
□ History of abnormal mammogram □ History of abnormal Pap
□ Other please specify Comments: _____

Immunizations:

Last Tetanus: _____
Last TB Test: _____Positive: □ Y □ N
Hepatitis A Series: _____
Hepatitis B Series: _____
Shingles: _____
Pneumococcal: _____
Did you have Chickenpox? □ Y □ N

Date of Last Preventative:

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

Past Surgeries:

Back ____ Sinus _____ Tonsils _____ Joint Surgery _____
Hernia _____ Appendix _____ Vasectomy _____
Gall Bladder _____ Tubal Ligation _____ Hysterectomy _____
Ovaries Removed? □ Y □ N
List Hospital Admissions (not surgeries): _____
_____
Other/Comments: _____

Medications:

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

Allergies:

Preferred Pharmacy? _____

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?

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	□	□	□	

□ 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: _____

Females Only:

Current method of Birth Control: _____
Has your husband had a vasectomy? □ Y □N
First day of last period? _____
Total # of Pregnancies: _____
Live Births: _____
Miscarriages/Abortions: _____

Please sign and date:

_____