Medical History Form

Patient Name:_____

Date:_____

Chief Complaint/Concerns:_____

_____

Last time lab work was done:_____ Last place lab work was done:_____

Medical issues

Have you **EVER** been diagnosed as having **ANY** of the following conditions?

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Anxiety
- ☐ Artery/Vein Problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bipolar Disorder
- ☐ Bladder issues
- ☐ Bleeding Problems
- ☐ Blood Clots
- ☐ Cancer
- ☐ Cataracts
- ☐ Colitis/Chrones
- ☐ Depression
- ☐ Diabetes
- ☐ Drug/ Alcohol Abuse
- ☐ Esophagitis/ Ulcers
- ☐ Fractures
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches/ Migraines
- ☐ Hearing Impairment
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Valve Problems
- ☐ Hepatitis A☐ B☐ C☐
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lung Disorders
- ☐ MRSA
- ☐ Osteoporosis/ Osteopenia
- ☐ Recurrent UTI
- ☐ PTSD
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Visual Impairment
- ☐ Severe Allergic Reactions
- ☐ Skin Conditions

Other Medical issues/conditions not listed above:

_____ **Drug Allergies:**_____

_____

_____

_____

Surgical History

- ☐ Appendix removed
- ☐ Gallbladder removed
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Cataract removal
- ☐ Cesarean Section
- ☐ Coronary Bypass
- ☐ Cardiac Catheterization
- ☐ Stent Placement
- ☐ Other Cardiac Surgery
- ☐ Spinal Fusion
- ☐ Removal of Lumps
- ☐ Biopsy
- ☐ Tonsil/ Adenoid removal

Other Surgical Procedures not listed above:_____

_____

_____

Health Maintenance (if applicable)

Colonoscopy:	Yes ☐ / No☐	Year:	Preformed at:

DEXA (Bone Density): Yes ☐ / No ☐ Year:	Preformed at:
Mammogram: Yes ☐ / No ☐ Year:	Preformed at:

Family History

Family Member	Alive / Deceased	Age	Medical Conditions
Father	Alive ☐ / Deceased ☐		
Mother	Alive ☐ / Deceased ☐		
Sister	Alive ☐ / Deceased ☐		
Brother	Alive ☐ / Deceased ☐		
Other	Alive ☐ / Deceased ☐		

Additional family medical history:_____

Social History

Have you ever or do you currently use any of the following?

Substance	Type	Yes / No	Start Date / Age	End Date / Age
Tobacco Products		Yes ☐ / No ☐		
Alcohol Products		Yes ☐ / No ☐		
Recreational Drugs		Yes ☐ / No ☐		

Immunization History

Influenza: Yes ☐ / No ☐ Year Received:	TDaP: Yes ☐ / No ☐ Year Received:
Pneumonia: Yes ☐ / No ☐ Year Received:	MMR: Yes ☐ / No ☐ Year Received:
Shingles: Yes ☐ / No ☐ Year Received:	RSV: Yes ☐ / No ☐ Year Received:
Tetanus: Yes ☐ / No ☐ Year Received:	HEP A: Yes ☐ / No ☐ Year Received:
COVID: Yes ☐ / No ☐ Year Received:	HEP B: Yes ☐ / No ☐ Year Received:
Polio : Yes ☐ / No ☐ Year Received:	HPV: Yes ☐ / No ☐ Year Received:

Medications

Medication Name	Dosage	Frequency
