

Medical History

Name: _____ Date of Birth: _____

Medical History: (Please check if you have or had any of the following)

<input type="checkbox"/> Allergies	<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Latex Allergies
<input type="checkbox"/> Anemia	<input type="checkbox"/> Fainting or Dizziness	<input type="checkbox"/> Liver Disease or Jaundice
<input type="checkbox"/> Asthma or hay fever	<input type="checkbox"/> Frequent colds/Pneumonia	<input type="checkbox"/> Loss/Gain of weight
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Nervous or Mental Disorder
<input type="checkbox"/> Bladder Trouble	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Pain in Arms or Hands
<input type="checkbox"/> Bursitis or Shoulder pain	<input type="checkbox"/> Goiter or Thyroid Trouble	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Cancer, Cysts, or Tumors	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Rheumatism or Arthritis
<input type="checkbox"/> Change of bowel habits	<input type="checkbox"/> Hepatitis or Cirrhosis	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Chest pain or pressure	<input type="checkbox"/> High or Low Blood Pressure	<input type="checkbox"/> Skin Trouble or Rashes
<input type="checkbox"/> Chronic cough or bronchitis	<input type="checkbox"/> Ill Effects from Medicine	<input type="checkbox"/> Swollen Joints
<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Indigestion or Heartburn	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Wrist or Elbow Spasm
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney or Bladder Disease	

Surgical History & Date/Age if known: _____ No surgeries

Hospitalizations: _____ No past hospitalizations

Date/Age: _____ Reason: _____
 Date/Age: _____ Reason: _____

Family History:

History of:

Father:	Alive or deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
Mother:	Alive or deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
Child:	Alive or deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
Child:	Alive or deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
Child:	Alive or deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown

Social History:

Tobacco Use: Yes No ___former or ___never Drug Use: Yes No Alcohol Use: Yes No
 Sexually Active: Yes No Ever had a Sexually Transmitted Disease? Yes No

Medications currently taking (List) Name/Dosage/How often:

Allergies: to medications, food, or latex (List): _____

Females Only: Is it possible that you may be pregnant? YES NO Date of last Menstrual Cycle: _____

Immunizations Up-To-Date? ___Current to my knowledge ___Not up-to-date ___Unknown (will discuss w/provider)

Injured at Work: YES NO Date/time of injury: _____

Today's Date _____