

Medical History Form

Name <small>(Last, First, M.I.):</small>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
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Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Previous or referring doctor:
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<input type="checkbox"/> yes <input type="checkbox"/> no Tobacco use? What?	How much?
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<input type="checkbox"/> yes <input type="checkbox"/> no Alcohol use? What?	How much?	Other drug use?
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PERSONAL HEALTH HISTORY

Childhood illness:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio
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Immunizations and dates:	<input type="checkbox"/> Tetanus <input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pneumonia <input type="checkbox"/> Influenza	
	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>	<input type="checkbox"/> Chickenpox	

List any medical problems that other doctors have diagnosed in the blank space below:

Have you ever had any of the following:

Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Blood clots	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Kidney disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Liver disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chronic bronchitis or emphysema	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Lupus or rheumatoid arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thyroid disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Ulcers	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Surgeries/Hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had