MEDICAL HISTORY INFORMATION SHEET

NAME: _____ AGE:_____ TODAY'S DATE: ____/____/_____

Birth Date: (M / D / Year) _____/_____/_____ Height ____ft____inches Weight _____lbs

REASON FOR TODAY'S EXAM _____

PAST MEDICAL HISTORY: Please check any illnesses/conditions which YOU have had.

☐ High Blood Pressure	☐ DVT	☐ Lung Disease	☐ Stroke
☐ High Cholesterol	☐ Pulmonary Embolus	☐ Asthma	☐ Diabetes
☐ Vein Trouble	☐ Tuberculosis	☐ Heart Trouble	☐ Pneumonia
☐ Kidney Disease	☐ Nervous Disorder	☐ Seasonal Allergies	☐ HIV
☐ Thyroid Problems	☐ Sinus	☐ Arthritis	☐ Hepatitis
☐ Drug Abuse/Alcoholism	☐ Tonsillitis	☐ Gastrointestinal	☐ Osteoporosis
☐ Joint Replacement	☐ Bleeding Tendencies	☐ Cancer:	If Yes, What Type _____

Other: _____

History of Serious Injuries / Illnesses? YES ☐ NO ☐ If yes, please describe below.

_____

SURGICAL HISTORY and or SURGICAL COMPLICATIONS? Please list

_____

FAMILY MEDICAL HISTORY: Please check any illnesses/conditions immediate FAMILY has had.

High Blood Pressure _____ ☐	DVT _____ ☐	Lung Disease _____ ☐	Stroke _____ ☐
High Cholesterol _____ ☐	Pulmonary Embolus _____ ☐	Asthma _____ ☐	Diabetes _____ ☐
Vein Trouble _____ ☐	Tuberculosis _____ ☐	Heart Trouble _____ ☐	Pneumonia _____ ☐
Kidney Disease _____ ☐	Nervous Disorder _____ ☐	Seasonal Allergies _____ ☐	HIV _____ ☐
Liver Disease _____ ☐	Seizures _____ ☐	Ear Problems _____ ☐	Sinus _____ ☐
Drug Abuse / Alcoholism _____ ☐	Thyroid Problems _____ ☐	Arthritis _____ ☐	Tonsillitis _____ ☐
Joint Replacement _____ ☐	Hepatitis _____ ☐	Gastrointestinal _____ ☐	Osteoporosis _____ ☐
Cancer: Type _____	Bleeding Tendencies _____ ☐		

Other: _____

SOCIAL HISTORY:

Occupation: _____ Marital Status:_____ Children: Yes ☐ No ☐ Live Alone: Yes ☐ No ☐

Tobacco Use: Never ☐ In the Past ☐ Presently ☐ How Much? _____ How Long? _____

Alcohol Use: Daily ☐ Occasional ☐ None ☐ Other substance use or abuse? Yes ☐ No ☐

Health Maintenance:

Last Tetanus Shot:_____ Age 65 and older: Pneumonia Shot:_____ Last STD Screening:_____

Age 50 and older: Colon Cancer Screening:_____ Location Performed:_____

Females Only: Last Pap Smear:_____ Age 40 and older: Mammogram:_____ Bone Density:_____

ALLERGIC TO LATEX: Yes ☐ No ☐ ALLERGIC TO MEDICATIONS: Yes ☐ No ☐

PLEASE LIST:_____

CURRENT MEDICATIONS: _____

_____

_____