MEDICAL HISTORY

NAME: _____ **Birth Date:** _____ **Date:** _____

1. Why are you seeing the Doctor today? _____ **2. How long have you had this problem?** _____

Medications: LEAVE BLANK IF YOU HAVE A MEDICATION LIST
Please list your prescribed and over-the-counter drugs, such as vitamins, aspirin, allergy meds, etc.

Name the Drug	Strength	Frequency Taken

Allergies to Medications No Yes, if so, please explain below:	
Name of drug	**Reaction you had**

Please list current pharmacy		
Name	**Phone Number**	**Address**

Please answer all of the following questions related to your current or past medical history.

Circle			**Describe your Problem**
NO	**YES**	Headaches	
NO	**YES**	Eyes/Vision	
NO	**YES**	Do you wear contact/glasses?	
_____		If seeing Ophthalmologist, when was last Exam?	
NO	**YES**	Ears, Nose, Throat	
NO	**YES**	Lungs, Breathing	
NO	**YES**	Heart Problems	
NO	**YES**	Digestion	
NO	**YES**	Bowel Problem	
NO	**YES**	Bladder Problem	
NO	**YES**	Diabetes	
NO	**YES**	High Blood Pressure	
NO	**YES**	Bleeding Problems	
NO	**YES**	Balance Problem	
NO	**YES**	Numbness/Tingling	
NO	**YES**	Blackout/Fainting	
NO	**YES**	Anxiety/Depression	
NO	**YES**	AIDS/HIV	
NO	**YES**	Cancer	
NO	**YES**	Arthritis	
NO	**YES**	Polio	
NO	**YES**	TB	
NO	**YES**	Epilepsy (Seizures)	

PAST MEDICAL / HOSPITALIZATION

Hospitalizations: (Medical & Surgical) Year Any Complications?

_____

_____

_____

_____

Family Medical History

Family Member	Age Now or at Death	Cause of Death	Any Health Problems if alive
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sibling 1 M F			
Sibling 2 M F			
Sibling 3 M F			

Social History

☐ Employed (occupation) _____ ☐ Work at home ☐ Student

Do you currently smoke? ☐ Yes ☐ No

If yes, how many packs per day?_____for years _____ years

If no, did you ever smoke and when did you quit? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how often? ☐ Daily ☐ 1-2 times/week ☐ 1-2 times/month

Do you or have you ever used recreational/illicit drugs? ☐ Yes ☐ No

Do you have any hearing impairments? ☐ Yes ☐ No Do you wear a hearing aid? ☐ Yes ☐ No

Do you have dentures? ☐ Yes ☐ No

Do you have children? Yes No # _____

Do you live alone? Yes No

Are you on a special Diet? Yes No Describe _____

Females Only - Please Complete

Menstrual Flow (please check all that apply): ☐ Regular ☐ Irregular ☐ Pain/Cramps

Days of Flow: _____ Length of Cycle: _____ Date (1st day) of last period: _____

If you no longer have menstrual cycle, please list year menses stopped: _____

Number of: Pregnancies _____ Live Births _____ Miscarriages _____ Abortions _____

Birth Control Method: _____ If Birth Control Pill, list name of Pill _____