

# Medical History

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_-\_\_\_\_-\_\_\_\_  
 Today's Date \_\_\_\_\_ History information supplied by:  Self  Other \_\_\_\_\_ Referred by \_\_\_\_\_  
 Marital Status:  Single  Married  Widowed  Divorced  Other \_\_\_\_\_  
 Why is patient here today? \_\_\_\_\_

Is patient allergic to or had an adverse reaction to any medications, foods, shell fish or dyes?  Yes  No If yes, list.

Is patient taking any prescription medications?  
 Yes  No If yes, list.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is patient taking any non-prescription medications (for example, aspirin or vitamins)?  Yes  No If yes, list.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has patient had any surgeries?  Yes  No If yes, list.  

Year	Type of Surgery

Year	Type of Surgery

Does patient exercise?  Yes  No  
 What type? \_\_\_\_\_ How often?  Seldom  
 Sometimes  Weekly  Daily How long?  
 0 - 15 minutes  15 - 30 minutes  30 minutes or more

Does patient drink alcohol?  Yes  No  
 Quit \_\_\_\_\_ years ago Type:  Beer  Wine  Liquor  
 How often did or does patient drink?  
 Seldom  Sometimes  Weekly  Daily

Does patient use tobacco?  Yes  No  
 Quit \_\_\_\_\_ years ago Type:  Cigarette Packs per day \_\_\_\_\_ for \_\_\_\_\_ years  Other \_\_\_\_\_

What type of work does patient do? \_\_\_\_\_  
 Full Time  Part Time  Retired  
 Hobbies \_\_\_\_\_

How many caffeine drinks does the patient drink per day?  
 N/A  1 - 2  3 - 4  5 or more

Has patient ever used street drugs?  Yes  No If yes, type:  Cocaine  Marijuana  Inhalants  Other

### Health History

Has patient, parents, grandparents, siblings, or children had or have any of the following? Check all that apply.

	Patient	Family		Patient	Family	
1. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	18. Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<b>For Office Use Only</b>
2. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	19. Muscle Problems	<input type="checkbox"/>	<input type="checkbox"/>	
3. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	20. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	
4. Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>	21. Blood Clots or Bad Veins	<input type="checkbox"/>	<input type="checkbox"/>	
5. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	22. Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	
6. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	23. Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>	
7. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	24. Bone/Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>	
8. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	25. Kidney/Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	
9. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	26. Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	
10. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	27. Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	
11. Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	28. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
12. High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	29. Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	
13. Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	30. Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	
14. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	31. Breast Problems	<input type="checkbox"/>	<input type="checkbox"/>	
15. Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	32. Female Problems	<input type="checkbox"/>	<input type="checkbox"/>	
16. Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	33. Other _____	<input type="checkbox"/>	<input type="checkbox"/>	
17. Mental Disorders	<input type="checkbox"/>	<input type="checkbox"/>	34. Other _____	<input type="checkbox"/>	<input type="checkbox"/>	

*Please turn the page over. The questionnaire continues on the back.*

