MEDICAL HEALTH HISTORY

Name: _____ **Date of Birth**: _____ **Today's Date**:_____

Past Medical History

☐ Alcoholism	☐ Chest Pain	☐ Heartburn	☐ Obesity
☐ Allergies	☐ Circulation problems	☐ Hepatitis C	☐ Osteoarthritis
☐ Anemia	☐ Crohn's disease/Colitis	☐ High blood pressure	☐ Osteoporosis
☐ Anxiety	☐ CVA (stroke)	☐ High cholesterol	☐ Thyroid disorder
☐ Arthritis	☐ Depression	☐ Irritable bowel disease	☐ Seizure disorder
☐ Asthma	☐ Diabetes	☐ Kidney disease	☐ Sleep apnea
☐ Atrial fibrillation	☐ Enlarged prostate	☐ Liver disease	☐ Ulcers
☐ Blood clots	☐ Gallbladder disease	☐ Lung Disease/Emphysema	☐ Valve disease
☐ Cancer	☐ Heart disease	☐ Mental illness	☐ Other_____
☐ Chest pain	☐ Heart failure	☐ Migraine headaches	☐ Other_____

Past Surgical History

Please list all prior surgeries. Include name of hospital, dates and any complications.

1._____

2._____

3._____

4._____

Other Hospitalizations, Serious Illnesses, Injuries

Please list reason for hospitalization, nature of illness or injury, name of hospital, and dates

1._____

2._____

3._____

4._____

PHYSICIANS LIST (Please list any other physicians currently assisting in your care)					
Specialty	**Physician**	**Specialty**	**Physician**	**Specialty**	**Physician**
Allergy/Immunology		Hematology		Pain Management	
Cardiology		Nephrology		Podiatry	
Chiropractor		Neurology		Psychiatry/Mental Health	
Dental		OB/GYN		Pulmonary Medicine	
Dermatology		Oncology		Rheumatology	
Endocrinology		Ophthalmologist		Sleep Medicine	
Gastroenterology		Optometrist		Urology	
General Surgery		Orthopedics		Other Specialty	

Do you have an advance directive/living will? Yes No (**circle one**)
If yes, please supply the office with a copy for your chart. If no, would you like one? Yes No (**circle one**)

Medications

List any prescription, herbal or over-the-counter medications that you are currently taking.

Medication name*	**Strength**	**Dosage/Directions**
Example: Aspirin	325mg	1 tab daily

Please list your preferred pharmacy address and phone number:

_____

Do you have allergies to medications? Yes or. No
If yes, please list drug(s) and reactions(s):

1._____

2._____

Family History

FAMILY HISTORY (Please check if your family has a history of any of these diseases)									
Condition	**Mother**	**Father**	**Maternal Grandparents**	**Paternal Grandparents**	**Brother**	**Brother**	**Sister**	**Sister**	**Additional Sibling(s)**
Cancer									
Diabetes									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Stroke									
Other									

If your mother, father, brothers, or sisters are deceased, please list their age at the time of their death and the cause:

Relationship	**Cause of death**	**Age at death**	**Relationship**	**Cause of death**	**Age at death**

Immunizations

Please list the last date of the below immunizations. Approximate dates are fine.

Date of last flu shot:	_____/_____ / _____	☐ None	☐ I'm not sure
Date of last pneumonia shot*:	_____/_____ / _____	☐ None	☐ I'm not sure
* Type: _____			
Date of last tetanus shot:	_____/_____ / _____	☐ None	☐ I'm not sure
Date of last shingles shot:	_____/_____ / _____	☐ None	☐ I'm not sure
Date of last HepB shot:	_____/_____ / _____	☐ None	☐ I'm not sure
Dates of Covid-19 vaccine	_____/_____/_____	☐ None	
	_____/_____/_____		
Other vaccines:	_____/_____/_____		

Health Maintenance

Date of last physical/preventative medical exam: _____

Are you receiving alternative care? ☐ Yes ☐ No

If yes, kind: ☐ Acupuncture ☐ Chiropractic ☐ Other: _____

Do you see a dentist on a regular basis? ☐ Yes ☐ No Date of last dental exam: ___/___/___

Adults only: Date of last cholesterol test? ___/___/____

Adults ages 50+ date of last colonoscopy: ___/___/____

Adults ages 65+ last osteoporosis screening (Dexa Scan): ___/___/____

Women ages 21+ last pap smear: ___/___/____

Women ages 40+ last mammogram: ___/___/____

Men ages 40+ last prostate exam: ___/___/____

Health Habits History

HEALTH HABITS HISTORY

Do you now/have you ever smoked? YES NO (circle one) If yes, how long have/did you smoke? ___ How many packs per day? ___

Did you quit? YES NO (circle one) If yes, what year did you quit? _____

How many alcoholic beverages do you drink per week? _____ How many days per week do you exercise? _____

In the past 6 months, have you had a regular problem with pain? YES NO Where? _____

Do you wear glasses/corrective lenses? YES NO Do you wear a hearing aid? YES NO

Patient Name or Representative: _____

Please Print

Signature: _____ **Date:** _____

Patient or Representative

If signed by Representative, relationship to patient:_____

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