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MEDICAL HISTORY

Patient Name: ____ **Date:** __________________

Drug Allergies: ____

____

☐ No Known Drug Allergies

Current Medications: ☐ See Current Medication Form ☐ No Medications

Past surgeries/hospitalizations with dates: ____

____

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Past Medical History:

☐ Allergies	☐ High Blood Pressure	☐ Bloating/Gas
☐ Arthritis	☐ High Cholesterol	☐ Colon Cancer
☐ Bronchitis	☐ High Triglycerides	☐ Colon Polyps
☐ Chronic Rash	☐ Prostate Disease	☐ Crohn's Disease
☐ Depression	☐ Sexual/Menstrual Dysfunction	☐ Constipation
☐ Diabetes	☐ Scarlet Fever	☐ Gallbladder problems
☐ Dizziness	☐ Shortness of Breath	☐ Hemorrhoids
☐ Fainting	☐ Pneumonia	☐ Irritable Bowel Syndrome
☐ Gout	☐ Rheumatic Fever	☐ Other:_______________
☐ Headache	☐ Pancreatitis	________________________
☐ Heart Palpitations	☐ Stomach Ulcer	________________________
☐ Heart Murmur	☐ Acid Reflux	
☐ Hepatitis B	☐ Anemia	
☐ Hepatitis C	☐ Bowel Irregularity	

Social History:

Current Smoker: ☐ Yes ☐ No
Ever Smoked: ☐ Yes ☐ No
Packs Daily: _________ How long: _______
Cups of Coffee per day: _____________
Other Caffeinated Drinks per day:_______
Current Exercise Routine: _____________
Alcohol Intake Type/Amount: __________
Fat Intake: ________________________
Hours of sleep/night:_________________
Blood/body fluids exposure: ☐ Yes ☐ No
Toxic Chemical Exposure: ☐ Yes ☐ No
Tattoos: ☐ Yes ☐ No
Explanation: _________________________
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Family Medical History:

	Father	Mother	Siblings	Children
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐
Convulsions	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐

For Women Only:

Age of first menstruation: ______ Days between each cycle: ______
Period lasts: ____ days. Flow is: ☐ Light ☐ Moderate ☐ Heavy
Date of last period: __/___/_____ Are you pregnant? ☐ Yes ☐ No
Total # of pregnancies: __________ Full term deliveries: ___________
Living children:_____________ Age of youngest: ________________
Last Pap exam: _____________ Last breast exam: ________________
Type of birth control: __________________________________