

Medical History

Name _____ Age _____ Date _____

This form is very important and helps guide me in obtaining a clearer understanding of your past health and present concerns. I understand you may not remember everything. Please do your best.

Please list concerns about your health, complaint or injury that brought you here today?

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Complete for each family member to the best of your knowledge with X in appropriate box

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood disorder / Anemia							
Diabetes							
Cancer or tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder disorder							
Stomach / Intestinal disorder							
Drug abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression / Mental Illness							
Other							
Age at Death							
Cause of Death							

HOSPITALIZATIONS: Have you have ever been hospitalized for any illness, operation or injury?

YEAR	OPERATION OR ILLNESS	NAME OF HOSPITAL	CITY AND STATE

MEDICINES – Mark an X in the box next to any of the following that you are currently taking

- | | | | |
|-------------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Oral contraceptives | <input type="checkbox"/> Acetaminophen -Tylenol | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Fiber supplements | <input type="checkbox"/> Cold tablets | _____ |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Blood pressure pills | <input type="checkbox"/> Tranquilizers | _____ |
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Sleeping pills | <input type="checkbox"/> Hay fever tablets | _____ |
| <input type="checkbox"/> Diet pills | <input type="checkbox"/> Blood thinning pills | <input type="checkbox"/> Insulin, diabetic pills | _____ |

DRUG ALLERGIES: _____

Please check any of the following you have had:

- ☐ Measles
 ☐ Mumps
 ☐ Chicken Pox
 ☐ German measles (Rubella)
 ☐ Scarlet Fever
 ☐ Rheumatic Fever

Have you had any serious illnesses, accidents or injuries not mentioned above?
