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MEDICAL HISTORY FORM

Name:____ DOB:________________________

Reason for appointment:____

Referring Physician:____

Primary Care Physician:____

Other MD:____

Question			Details
Do you take any prescription or non-prescription medication, vitamins or herbals?	Yes	No	Please list the reason why you take this medication:
Are you allergic to any medications or food?	Yes	No	List:
Do you or have you ever smoked tobacco?	Yes	No	How much: How many years: Quit:
Do you drink alcohol?	Yes	No	How much/often:
Have you ever used illicit drugs?	Yes	No	When and what kind:
Do you bleed or bruise easily?	Yes	No	
Have you ever been hospitalized?	Yes	No	When and why?
Have you ever had surgery?	Yes	No	When and why?
Have you ever had a problem after anesthesia?	Yes	No	What:
Are there any non-cancer illnesses that run in your family?	Yes	No	List:

Please turn over

Medical Problems? Please explain below: Height:_________ Weight:________

Heart disease	Yes No	
High blood pressure	Yes No	
Diabetes	Yes No	
Thyroid problems	Yes No	
High cholesterol	Yes No	
Dry eyes/ Eye problems	Yes No	
Heart murmur	Yes No	
Stomach problems	Yes No	
Liver problems	Yes No	
Respiratory problems	Yes No	
Arthritis	Yes No	
Seizures or epilepsy	Yes No	
Blood disorders	Yes No	
Cancer	Yes No	
Other	Yes No	
Wear glasses?	Yes No	
Hearing problems?	Yes No	

Do you have any of the following symptoms **now**?

□ Fever	□ Weight loss	□ Fatigue	□ Visual disturbance
□ Hearing loss	□ Nasal congestion	□ Sore throat	□ Hoarseness
□ Cough	□ Shortness of breath	□ Chest pain	□ Abdominal pain
□ Pain upon urination	□ Muscle/Joint pain	□ Rash	□ Weakness
□ Numbness	□ Breast pain	□ Nipple discharge	□ Swollen/warm breast

Pharmacy:____

Do you have any cultural/religious practices that may affect your treatment? □Yes □No

If so, what:____

What is your present occupation?____

I certify that the above information is complete and accurate.

Patient signature:_______________________________________ Date:____________