



Patient Name _____ Account No. _____ DOB _____ Age _____

Patient Medical History Form: **Please provide the following medical information to the best of your ability:**

| | |
|---|-----------------------------------|
| Date: | List Any Allergies to Medications |
| What are your concerns for today's visit? | |
| | |
| | |

Past Medical History:

1) Please check the "Yes" or "No" box to indicate whether you have any of the following illnesses: If "Yes", please explain.

| | <u>Yes</u> | <u>No</u> | |
|------------------------------------|--------------------------|--------------------------|-------|
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hypertension (high blood pressure) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Thyroid Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Stomach or Intestinal Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Kidney Disorders | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Neurological Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other Medical Diagnosis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

2) Please list any operations (and dates) you have ever had:

3) Please list any medications (and amounts, times per day) you take currently (including aspirin and vitamins):

Social History:

| | <u>Yes</u> | <u>No</u> | Please list details below: |
|-------------------------------------|--------------------------|--------------------------|----------------------------|
| Do you smoke? List how much. | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| If no, did you smoke previously? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| How often do you drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| What type of alcohol do you prefer? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| What is your occupation? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Family History:

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses:

If "Yes", please indicate which relative(s) have the problem.

| | <u>Yes</u> | <u>No</u> | |
|---------------------|--------------------------|--------------------------|-------|
| Hearing problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Allergy | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Bleeding disorder | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Anesthesia problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Reviewed by:

