**PATIENT MEDICAL HISTORY INFORMATION**

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI:\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **HEALTH COMPLAINT/REASON FOR TODAY’S VISIT** |
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| **MEDICAL HISTORY -** List chronic, serious or significant health conditions with date of onset/diagnosis |
| Date | Health Condition |
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| **SURGICAL HISTORY** - List surgeries and dates |
| Date | Surgery |
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| **MEDICATIONS/SUPPLEMENTS** – List current prescription medications, over the counter medications and supplements |
| Name | Strength (e.g. 10 mg tablets) | How is it taken (e.g. 10 mg 2x a day) | Daily or as needed |
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| **ALLERGIES -** List all medication allergies and reactions |
| Name of Medication | Brief description of your reaction (e.g. rash) |
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| **FAMILY MEDICAL HISTORY** - List serious health conditions |
| Relation | Health Conditions and/or Cause of Death | Age if Living | Age at Death |
| GRANDPARENTS |  |  |  |
| FATHER |  |  |  |
| MOTHER |  |  |  |
| BROTHERS |  |  |  |
| SISTERS |  |  |  |

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| **SOCIAL HISTORY** |
| Marital Status:  | Occupation:  |
| Exercise (*circle*): *Active 1/wkly 1-3/wkly 4+/wkly Sedentary Other:* |
| Alcohol Use *(circle)*: *Never Currently every day Currently some days Former*Amount Used: |
| Tobacco Use *(circle)*: *Never Currently every day Currently some days Former*Amount Used: Age started: Age stopped:  |
| Recreational Drug *(circle, if yes please provide details)*: No Yes:  |

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| **IMMUNIZATIONS HISTORY** – List shots, date given and booster number if known (e.g. DTaP 1/2/11, #3) |
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| **ADDITIONAL MEDICAL INFORMATION** – Please use the space below to list any other important information |
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*If you need additional space to complete information use a separate piece of paper, attach to this form and check this box. Thank you.*