Medical History Form

Name: _____Date of Birth: _____

Past Medical History

Circle if you have ever been diagnosed with any of the following major medical problems:

Pulmonary: Asthma COPD Embolus **Endocrine:** Diabetes Hypothyroidism Hyperthyroidism

Cardiac: Heart Attack Arrythmia Murmur High Blood Pressure High Cholesterol

Gastrointestinal: Ulcers GI Bleed Hepatitis Irritable Bowel Diverticulitis Reflux Crohn's

Neurologic: Stroke Parkinson's Depression Seizures MS Psychiatric Illness

Urologic: Stones Kidney Cancer Bladder Cancer Testicular Cancer Prostate Cancer Incontinence ED

Other: STDs AIDS/HIV Fibromyalgia Bleeding Disorder Arthritis Glaucoma Anemia Phlebitis

Additional Medical History: ____Influenza Vaccine ____Pneumonia

Surgical History

Surgery Name	**Date**	**Surgery Name**	**Date**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Anesthesia complications: _____

Hospitalizations (exclude surgeries listed above)

Hospitalization Reason	**Date**	**Hospitalization Reason**	**Date**
_____	_____	_____	_____
_____	_____	_____	_____

Family History

Mother: ALIVE or DECEASED Major Medical Problems: _____

Father: ALIVE or DECEASED Major Medical Problems: _____

Other Family History: _____

Social History

Marital Status: Married Single Divorced Widowed

Tobacco Use: Never Previous: ___#years ___#packs per day Current: ____years ___packs per day

Current Medications (include over the counter, vitamins, herbal supplements, etc.

Medication Name	Dose	When Taken	Medication Name	Dose	When Taken
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

ALLERGIES: _____

Preferred Pharmacy: _____

To the best of my knowledge, this form has been accurately answered, I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary services I may need. Patient or Responsible Party Signature: _____ Date: _____