MEDICAL HISTORY SHEET **NAME:**_____

PAST MEDICAL HISTORY **DATE OF BIRTH:**_____

Check 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 ☐ Arrhythmia ☐ 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:

VACCINE: ☐ **Influenza** ☐ **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 DECEASED	**Major Medical Problems:**	
Father	ALIVE DECEASED	**Major Medical Problems:**	
Other Family History:			

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Tobacco Use: ☐ Never ☐ Previous: ____#years ____#packs/day ☐ Current: _____years _____packs/day
Alcohol Use: ☐ Never ☐ Occasionally/Rarely ☐ Often - quantity:_____
Occupation & Prior Occupation (if Retired):_____

CURRENT MEDICATIONS

(include over-the-counter, medications, vitamins, herbal supplements- write additional on separate sheet of paper if necessary)

Medication Name	Dose	When Taken	Medication Name	Dose	When Taken

Allergies:_____

Preferred Pharmacy:_____

To the best of my knowledge, this form have 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 service I may need.

_____ _____

Signature **Date**