



MEDICAL HISTORY

PLEASE DO NOT MAIL

Chart # \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ M / F Age \_\_\_\_\_ Marital Status: M S D W

Family Physician: \_\_\_\_\_ City, State: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Any tests done? (Please list) \_\_\_\_\_

Past Medical History: (Please check No or Yes for Each of the following)

Table with 4 columns of medical conditions and Yes/No checkboxes. Conditions include Rheumatic Fever, Pneumonia, Tuberculosis, Asthma, Emphysema, Bronchitis, Carotid Artery Disease, High Blood Pressure, Heart Disease, Angina, Irregular Heartbeat, Heart Attack, Congestive Heart Failure, Stroke, Claustrophobia, Thyroid Disorder, Diabetes, Liver Disease/Hepatitis, Kidney Disease, Hiatal Hernia, Ulcers, Diverticulosis, Arthritis, Phlebitis, Anemia, Bleeding Problems, Blood Diseases, Radiation/Chemo, Memory Loss, Alzheimer's, Psychiatric Disorder, Seizures.

Have you or a family member been diagnosed with the following? (Check if Yes) Other \_\_\_\_\_

Creutzfeldt-Jakob Disease \_\_\_\_\_ Fatal Familial Insomnia \_\_\_\_\_
Gerstmann-Straussler-Scheinker Disease \_\_\_\_\_ Have you ever received injections of hormones to increase your height? \_\_\_\_\_

Hospitalizations: (Please list any relevant surgery or hospitalization)

Table with 4 columns: No/Yes, Date, No/Yes, Date. Rows include Eye Surgery, Thyroid/Neck, Heart, Lungs, Mastectomy, Stomach/Abdomen, Gallbladder, Appendectomy, Hernia, Back, Cancer, Prostate, Hysterectomy, Other.

Present Prescription & Non-Prescription Meds: (List name, dose, frequency)

Blank lines for listing current medications.

Allergies to Medications: No Known Allergies
Latex sensitivity: Yes No

Family History table with columns: Family Member, Living? (Yes/No), Medical Problems or cause of death.

Social History: Do (did) you - Smoke? Yes No
How much per day?
For how many years?
Drink alcohol? Yes No
How much per day?
Recreational Drug Use? Yes No
How many years?

Review of Systems: Do you have these now? If yes, explain:

Table with 4 columns: No/Yes, System Name, No/Yes, System Name. Systems include Skin, Head, Eyes, Ears, Nose/Mouth/Throat, Neck, Pulmonary, CV, GI, MS, Neuro, Psych.