Medical History Form

date:

Name:		date of birth:	age:
Address:			
City:	State:	Zip:	
Phone number:			
Email:			
What is the main reason for your visit today?			

Medical History Information

Height:	Weight:	BP:	o2:
(Office staff will obtain vitals)		pulse:	temp:
Who is your primary care provider/physician?			
Date of last physical examination:			
☐ Normal	☐ Abnormal	☐ Never	☐ Can't remember

List all **supplements** and medications you currently take:

Name	Dose	Frequency	Reason for taking
Do you have any drug allergies? Y / N			
If yes, please list:			

Social/Lifestyle

Marital Status	☐ Married	☐ Single	☐ Divorced	☐ Widowed	
What is your occupation?					
Do you currently use tobacco products?			Y / N		
Did you use tobacco products in the past?			Y / N		
When did you stop?		How long did you use them for?			
What did/do you use?	☐ Cigarettes (# packs/day)			☐ Cigars	☐ Pipe ☐ Chew
Do you drink alcohol?	Y / N		How many drinks per week?		
Do you use recreational drugs?		Y / N	What and how often?		
Do you eat a healthy diet?		Y / N	What about your diet is not healthy?		
How much water do you drink daily?					
Do you drink caffeine?	Y / N	What form and how much daily?			
How many times do you exercise each week?					
How many hours of sleep do you get each night?					
Rate your average energy level: (0 = no energy, 10 = full of energy all day)		0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10			
Do you have chronic pain?		Y / N	Where?		

Past Medical History

Alcoholism/Cirrhosis	Y / N	Diabetes	Y / N
Anemia (low iron)	Y / N	Gallbladder issues	Y / N
Arthritis	Y / N	Crohns/colitis/IBS	Y / N
Asthma/emphysema	Y / N	Heart disease/attack	Y / N
Blood disorders/clots	Y / N	Hepatitis/jaundice/liver	Y / N
Bone or spine problems	Y / N	High blood pressure	Y / N
cancer	Y / N	Anxiety/depression	Y / N
Stroke	Y / N	Thyroid (hyper or hypo)	Y / N
Kidney disease	Y / N	Ulcers/stomach pain	Y / N
Osteoporosis	Y / N	Frequent sinus infections	Y / N
Seasonal allergies	Y / N	Lung disease	Y / N
Prostate problems	Y / N	Seizures	Y / N
Were you a healthy child	Y / N	Other significant illness	
List any significant surgical procedures			

Family Medical History

Alcoholism/Cirrhosis	Y / N	Diabetes	Y / N
Anemia (low iron)	Y / N	Gallbladder issues	Y / N
Arthritis	Y / N	Crohns/colitis/IBS	Y / N
Asthma/emphysema	Y / N	Heart disease/attack	Y / N
Blood disorders/clots	Y / N	Hepatitis/jaundice/liver	Y / N
Bone or spine problems	Y / N	High blood pressure	Y / N
cancer	Y / N	Anxiety/depression	Y / N
Stroke	Y / N	Thyroid (hyper or hypo)	Y / N
Kidney disease	Y / N	Ulcers/stomach pain	Y / N
Osteoporosis	Y / N	Lung disease	Y / N
Prostate problems	Y / N	Seizures	Y / N
Were you adopted?	Y / N	Other significant illness	

Your answers should include your grandparents, parents & siblings only

Wellness/Health Maintenance Screenings

MEN

Date of last rectal prostate/testicular exam:			
☐ Normal	☐ Abnormal	☐ Never	☐ Can't remember
Date of last colonoscopy (if over age 50):			
☐ Normal	☐ Abnormal	☐ Never	☐ Can't remember

WOMEN

Date of last mammogram, breast thermography, or ultrasound:			
☐ Normal	☐ Abnormal	☐ Never	☐ Can't remember
Date of last breast exam by medical provider:			
☐ Normal	☐ Abnormal	☐ Never	☐ Can't remember
Date of last PAP and pelvic exam:			
☐ Normal	☐ Abnormal	☐ Never	☐ Can't remember
Date of last colonoscopy (if over age 50):			
☐ Normal	☐ Abnormal	☐ Never	☐ Can't remember

Obstetrical/gynecological history

Age at start of periods?	First day of your last period?
How long between periods?	How long do you bleed?
Are you taking birth control pills?	Do you have an IUD? Mirena / Copper
Have you gone through menopause?	What age did periods stop?
Did you have a hysterectomy?	Were both uterus and ovaries removed?
Do you perform monthly breast self exams?	When was hysterectomy?

Any other information you feel is pertinent:

Signature: _____ Date: _____