

MEDICAL HISTORY FORM



Patient Name _____ Birth Date _____ Today's Date _____

Information provided by: Patient Spouse Family Significant Other Facility

SOCIAL HISTORY

Occupation _____ Marital Status: Single Married Divorced Widow
 Do family/friends provide care for you? _____
 Do you have an Advance Directive/Living Will? _____
 Do you have communication needs that may affect your medical care? _____
 Do you experience verbal or physical abuse in your relationship with your spouse/significant other? _____
 Do you smoke? _____ #Packs/Day _____ Age started _____ Date quit? _____
 Do you drink alcohol? _____ #Drinks/Day _____
 How much caffeine do you consume? _____
 Do you use street drugs? _____ Age started _____ What type? _____
 Do you have excessive exposure at home or work to: (circle all applicable) Fumes Dust Solvents Air-borne particles Noise

MEDICAL CONDITIONS (Please circle any past or present conditions):

Diabetes	Yes No	Stroke	Yes No	Convulsion	Yes No
Hypertension	Yes No	Heart Trouble	Yes No	Bleeding Tendency	Yes No
Cancer	Yes No	Arthritis/Gout	Yes No	Venereal Disease	Yes No
Acute Infections	Yes No	Hereditary problems	Yes No	Thyroid Problems	Yes No

If under age 18, did your mother receive prenatal care? Yes No Was the delivery normal? Yes No

MEDICATIONS

Please list any prescription and non-prescription (i.e. vitamins, aspirin) medications you take, with dose and frequency:

ALLERGIES Please list allergies/reactions (drugs/other)

IMMUNIZATIONS

If under age 12, are immunizations up to date? Yes No Where were they administered? _____
 When was your last flu shot? _____ Pneumonia shot? _____ Tetanus shot? _____

FAMILY HISTORY

Please mark each box as applicable:

	Year of Birth	Age When Deceased	High Blood Pressure	Stroke	Heart Disease	Colon Cancer	Breast Cancer	Prostate Cancer	Other Cancer	Thyroid Disease	Diabetes
Father											
Mother											
Siblings											
Children											

Patient reviewed: _____ Date _____ Reviewed _____ Date _____ Reviewed _____ Date _____

Staff member reviewed: _____ Date _____ Reviewed _____ Date _____ Reviewed _____ Date _____