Medical History Form (Date _____)

Name: _____ DOB: ___/___/_____ Gender: _____
Age: _____ Current Weight: _____ Current Height: _____
Occupation: _____

Date of last physical examination: _____ Physician: _____

Please list out ***medications/supplements*** below- indicate strength, and reason for use.

Name	Dosage/day	Prescribing Doctor	Reason for use
ALLERGIES:			

ENTERED / SCANNED DATE: _____ by : _____

Social History

Marital Status: ___ Single ___Married ___Divorced ___ Partner ____Widowed ____Other _____
Name of Spouse/Partner:
Who lives at home with you: # _____ Adults #_____ Children
Do you have any religious/medical restrictions? _____ If yes, what? _____
Caffeine intake: _____None _____Coffee/Tea _____Cups/day _____Soda _____Cups/day
Diet: _____ Good ____Fair ____ Poor How many meals per week outside of home:_____
Alcohol (drinks per week) _____ Type: _____ Beer _____ Wine _____ Liquor ____ Mixed
Smoking: ___Pipe ___Cigarettes ___Chewing Tobacco ___ Former Smoker _____ Year Quit Amount smoked/used per day: _____ NON Smoker _____
Recreational Drug Use: Type:_____ Frequency _____ Used in the past? _____ Last year of use: _____

Current Family Health Status

Member	Current Disease	Health Status (good/fair/poor)	D.O.B.	Deceased	Cause of Death
Father					
Mother					
Paternal Grandmother					
Paternal Grandfather					
Maternal Grandmother					
Maternal Grandfather					
Brother (s)					
Sister (s)					
Spouse/Partner					

ENTERED / SCANNED DATE: _____ by :_____

FAMILY Medical History

Please indicate (x) all family members* medical history (*Mother/Father/Brother/etc)

		Relationship			Relationship
	Heart Disease			Blood Disorder	
	High Blood Pressure			Stomach Disorder	
	Diabetes			Obesity	
	High Cholesterol			Drug/Alcohol Abuse	
	Stroke			Mental Illness	
	Cancer (type)			Thyroid Disorder	

PAST MEDICAL HISTORY ***(Do you have a history of any of the following?)***

- ☐ Stroke
- ☐ Phlebitis
- ☐ Anemia
- ☐ High Blood Pressure
- ☐ Poor Circulation
- ☐ Vascular Disease
- ☐ Heart Attack
- ☐ Heart Condition
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Thyroid Problem
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Arthritis
- ☐ Gout
- ☐ Osteoporosis
- ☐ Rheumatic Fever
- ☐ Lyme Disease
- ☐ Nerve Disorder
- ☐ Sciatica
- ☐ Epilepsy
- ☐ Psychiatric Disorder
- ☐ Alzheimer's
- ☐ Headache
- ☐ Glaucoma
- ☐ Hearing / Ear Disorder
- ☐ Keloid / Thick Scar
- ☐ Cancer- Type:_____
- ☐ Smoker ☐ Previous Smoker- yr quit _____

PREVIOUS SURGERIES / YEAR PERFORMED / PLACE PERFORMED

_____

_____

Last Colonoscopy: _____ Normal / Abnormal Facility Performed at: _____

Last Mamogram: _____ Normal / Abnormal Faciltiy Performed at: _____

Last PSA (Men) _____ Normal / Abnormal Last Pap (Women) _____ Normal / Abnormal

Influenza Vaccine ☐ Yes ☐ No If yes when:_____ Where: _____

Pneumonia Vaccine ☐ Yes ☐ No If yes when: _____ Where: _____

Shingles Vaccine ☐ Yes ☐ No If yes when:_____ Where: _____

Dexa (Bone Density Scan): ☐ Yes ☐ No If yes when:_____ Where: _____

REVIEW OF SYSTEMS *(Please check if you've EVER had any of the following)*

CONSTITUTIONAL
- ☐ Fever
- ☐ Weight Loss
- ☐ Lethargy

GENITOURINARY
- ☐ Frequent Urination

NEUROLOGICAL
- ☐ Headache
- ☐ Fainting
- ☐ Dizziness
- ☐ Depression
- ☐ Convulsion/Seizure
- ☐ Numbness

ENDOCRINE
- ☐ Night Sweats
- ☐ Thyroid Disease
- ☐ Frequent Thirst
- ☐ Heat ☐ Cold intolerance

MUSCULOSKELTAL
- ☐ Pain
- ☐ Muscles ☐ Neck
- ☐ Back ☐ Hips
- ☐ Knees ☐ Ankles
- ☐ Feet
- ☐ Limited ROM
- ☐ Limited Strength

CARDIOVASCULAR
- ☐ Shortness of Breath
- ☐ Chest Pain (Angina)
- ☐ Heart Palpitaions
- ☐ Cold Extremities
- ☐ Poor Circulation

SKIN
- ☐ Rash
- ☐ Itching
- ☐ Dry Skin
- ☐ toe/fingers nail changes
- ☐ Sores / Skin Lesions

GASTROINTESTINAL
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Bloody/dark stool
- ☐ Heartburn/GERD
- ☐ Loss of Appetite

HEMATOLOGICAL
- ☐ Blood Thinners
- ☐ Easy bruising
- ☐ Blood Abnormalities
- ☐ Lymph node enlargement

ANY PROBLEMS NOT LISTED: _____

_____

Signature: _____ Date: _____

ENTERED / SCANNED DATE: _____ by :_____