Medical History

Date: _____/_____/_____

Name: _____ **DOB:** _____/_____/_____

Reason for Visit: Routine Physical _____ Problem/Establish Care _____

Describe Problem: _____

Please circle your Marital Status: **Single** **Married** **Divorced** **Widowed** **Separated**

If married, spouses name: _____

Children's Names and Ages: _____

Occupation: _____ **Employer:** _____

Do you have any known allergies? Yes _____ No _____

Please List Allergies and Their Reactions

Allergy	Reaction	Allergy	Reaction

Please List Medications Including Prescriptions, Over-the-Counter, and Vitamins/Herbs

Drug Name	Dose	Drug Name	Dose

Social History (Please Check)

Do You Use a Seatbelt? Yes _____ No _____

Do You Use Sunscreen? Yes _____ No _____

Do You Exercise? No _____ Less than 3 times per week: _____ More than 3 times per week: _____

Do You Currently Smoke? No _____ Yes _____ **Are you a Former Smoker?** No _____ Yes _____

- Packs per Day: _____ Number of Years: _____

Do You Consume Alcohol? No _____ Yes _____

- Drinks per day: _____ Drinks per week: _____

Name: _____ DOB: _____/_____/_____

Please Check if You or a Blood Relative Have Been Diagnosed with or Have Any of These Medical Conditions

	Yes	No	What Blood Relative? (Mother, Father, etc.)
Abnormal Pap			
Alcohol Abuse			
Anemia			
Anxiety			
Arthritis			
Asthma			
Blood Disorder			
Blood Transfusion			
Bowel Disorder (What Type?)			
Cancer (What Type?)			
Chronic Lung Disease			
Colitis			
Deep Vein Thrombosis			
Depression			
Diabetes			
Drug Abuse			
Gall Bladder Disease			
Glaucoma			
Gout			
Hay Fever			
Headaches/Migraines			
Heart Disease			
Hemorrhoids			
Hepatitis/Liver Disease			
High Blood Pressure			
Impotence/Erectile Dysfunction			
Kidney Disease			
Kidney Stones			
Rheumatic Fever			
Skin Disease			
T.B.			
Thyroid Disease			
Venereal Disease			
Other			

Name: _____ DOB: _____/_____/_____

Are You Experiencing Any of the following Symptoms?

	Yes	No
Abdominal Discomfort		
Blood in Stool		
Change in Bowel Habits		
Chest Pain/Tightness		
Constipation		
Diarrhea		
Difficulty Urinating		
Frequent Urination		
Head/Neck Irritation		
Headaches		
Indigestion		
Lightheadedness		
Low Back Pain/Problems		
Nausea		
Palpitations		
Persistent Cough		
Shortness of Breath		
Swollen Ankles		
Unexplained Weight Loss/Gain		
Vomiting		
Other		

When Was Your Last:

	Date
Flu Vaccine	
Tetanus Vaccine	
Pneumovax Vaccine	
Hepatitis B Vaccine	
Gardasil/HPV Vaccine	
TB Skin Test	
Pap Smear	
Mammogram	
Colonoscopy	
Bone Density	
Other	

Please List Any Operations or Hospitalizations

Surgery/Reason	Date	Surgery/Reason	Date