Medical History

Name: _____**Date of Birth:**_____

Medical History: (Please check if you have or had any of the following)

□ Allergies	□ Eye Problems	□ Latex Allergies
□ Anemia	□ Fainting or Dizziness	□ Liver Disease or Jaundice
□ Asthma or hay fever	□ Frequent colds/Pneumonia	□ Loss/Gain of weight
□ Back Problems	□ Frequent Headaches	□ Nervous or Mental Disorder
□ Bladder Trouble	□ Gallbladder	□ Pain in Arms or Hands
□ Bursitis or Shoulder pain	□ Goiter or Thyroid Trouble	□ Rheumatic Fever
□ Cancer, Cysts, or Tumors	□ Heart Trouble	□ Rheumatism or Arthritis
□ Change of bowel habits	□ Hepatitis or Cirrhosis	□ Shortness of Breath
□ Chest pain or pressure	□ High or Low Blood Pressure	□ Skin Trouble or Rashes
□ Chronic cough or bronchitis	□ Ill Effects from Medicine	□ Swollen Joints
□ Dermatitis	□ Indigestion or Heartburn	□ Varicose Veins
□ Diabetes	□ Irregular Heart Beat	□ Wrist or Elbow Spasm
□ Epilepsy	□ Kidney or Bladder Disease	

Surgical History & Date/Age if known: _____No surgeries

_____

_____

Hospitalizations: _____No past hospitalizations

Date/Age:_____Reason:_____

Date/Age:_____Reason:_____

Family History: **History of**:

Father:	Alive or deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
Mother:	Alive or deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
Child:	Alive or deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
Child:	Alive or deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
Child:	Alive or deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown

Social History:

Tobacco Use: Yes No ___former or ___never Drug Use: Yes No Alcohol Use: Yes No

Sexually Active: Yes No Ever had a Sexually Transmitted Disease? Yes No

Medications currently taking (List) Name/Dosage/How often:

_____

_____

_____

_____

Allergies: to medications, food, or latex (List):_____

Females Only: Is it possible that you may be pregnant? YES NO Date of last Menstrual Cycle:_____

Immunizations Up-To-Date? ___Current to my knowledge ___Not up-to-date ___Unknown (will discuss w/provider)

Injured at Work: YES NO Date/time of injury:_____

Today's Date_____