MEDICAL HISTORY FORM

Patient Name _____ Date _____
Date of Birth _____ Social Security Number _____
Home Address _____
City/State/Zip Code _____ Home Phone _____

1. Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
2. Do you Smoke? ☐ Yes ☐ No Type of Tobacco: ☐ Cigarettes ☐ Cigar ☐ Smokeless Tobacco
   If yes, how much? ☐ Less than 1 pack per day ☐ 1 pack per day ☐ More than 1 pack per day
3. Do you drink alcohol? ☐ Yes ☐ No How much? ☐ Daily ☐ Weekly ☐ Seldom ☐ Never

Past Medical History: ☐ None ☐ High Blood Pressure ☐ Heart Disease ☐ Diabetes ☐ Asthma
Other: _____
Dominant Hand ☐ Right ☐ Left

Past Surgical History		Current Medications	Drug Allergies
1. _____	Date _____	1. _____	1. _____
2. _____	Date _____	2. _____	2. _____
3. _____	Date _____	3. _____	3. _____
4. _____	Date _____	4. _____	4. _____

Past Injury History	Work Related?	
1. _____	☐ Yes ☐ No	Date _____
2. _____	☐ Yes ☐ No	Date _____
3. _____	☐ Yes ☐ No	Date _____

Previous Family Medical History:

Father	Mother

Review of Systems (Check the following conditions you have had in the past 6 months):

Constitutional:	☐ Fever	☐ Recent Weight Gain		☐ Recent Weight Loss	
HEENT:	☐ Headaches	☐ Blurred Vision	☐ Ear Pain	☐ Sore Throat	
Cardiovascular:	☐ Chest Pain	☐ Palpitations	☐ Fee/Ankle Swelling		
Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of Breath		
GI:	☐ Vomiting	☐ Diarrhea	☐ Constipation	☐ Bloody Stool	
Urinary:	☐ Frequency	☐ Pain	☐ Burning	☐ Bloody in Urine	
Musculoskeletal:	☐ Joint Pain	☐ Swelling	☐ Muscle Pain		
Skin:	☐ Rash	☐ Mole Change	☐ Bruise Easy		
Neurological:	☐ Dizziness	☐ Slurred Speech	☐ Fainting	☐ Numbness	☐ Weakness
Endocrine:	☐ Excessive Thirst	☐ Excessive Hunger	☐ Frequent Urination	☐ Intolerance to Heat	☐ Intolerance to Cold

_____ _____
Patient Signature Date