MEDICAL HISTORY FORM

Patient Information				
Name	DOB	Gender: M/ F/Other: _____		
Address			Phone:	
Emergency Contact				
Name:	Relationship:		Phone:	
Insurance Information				
Insurance Provider		Policy number		

Personal history *(check all that apply)*	
☐ No known medical conditions ☐ Allergies (Drug, Food, Environmental) ☐ Anemia ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Blood transfusion ☐ Cancer (Specify: _____) ☐ Congestive heart failure ☐ COPD / Emphysema ☐ Depression ☐ Diabetes (Type 1 / Type 2) ☐ Epilepsy / Seizures ☐ GERD (Acid Reflux) ☐ Glaucoma ☐ Gout	☐ Heart Attack / Heart Disease ☐ High Blood Pressure (Hypertension) ☐ High Cholesterol ☐ HIV/AIDS ☐ Kidney Disease / Kidney Stones ☐ Liver Disease / Hepatitis ☐ Migraines ☐ Osteoporosis ☐ Stroke ☐ Substance Abuse (Alcohol / Drugs) ☐ Thyroid Disease (Hypo / Hyper)\ ☐ Tuberculosis ☐ Ulcers
Other medical issues:	

Treatments/Medications				
Name(s)	Dosage(s)	Frequency	Purpose	Note(s)

Surgeries/Procedures (with dates):	Allergies

Family history *(check all that apply)*	
☐ No known family history of medical conditions ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Thyroid Disease ☐ Kidney Disease ☐ Mental Health Conditions (Depression, Anxiety, etc.) ☐ Autoimmune Diseases ☐ Other: _____

Social history		
Factor	**Circle one**	**Most recent date**
Tobacco Use	Never / Former / Current	
Alcohol Use	Occasional / Moderate / Heavy	
Recreational Drugs	No / Yes (Specify)	
Exercise Routine	[ ] Times per week	

Review of Systems *(Check any symptoms that you are experiencing)*		
General	*Eyes*	*Cardiovascular*
☐ Fatigue ☐ Fever or chills ☐ Unexplained weight loss/gain	☐ Vision changes (blurry, double vision) ☐ Hearing loss or ringing ☐ Sore throat / Hoarseness	☐ Chest pain or tightness ☐ Palpitations (fast or irregular heartbeat) ☐ Swelling in legs or feet
Respiratory	*Gastrointestinal*	*Neurological*
☐ Shortness of breath ☐ Chronic cough ☐ Wheezing	☐ Abdominal pain ☐ Nausea or vomiting ☐ Diarrhea or constipation	☐ Headaches or migraines ☐ Dizziness or lightheadedness ☐ Numbness or tingling
Musculoskeletal	*Psychiatric*	*Other (please list)*
☐ Joint pain or stiffness ☐ Muscle weakness ☐ Back pain	☐ Depression or feeling down ☐ Anxiety or panic attacks ☐ Sleep disturbances (insomnia, nightmares)	
Additional notes		

Patient name		Date
Patient signature		Date