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: ☐ Heart surgery ☐ Cholecystectomy ☐ Appendectomy, ☐ C-section ☐ Hysterectomy ☐ Bladder ☐Colonoscopy ☐EGD ☐ Joint ☐Other ___	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	Check one	Most recent date *(if applicable)*
Tobacco Use	☐ Cigarettes ☐ Vaping ☐ Tobacco	
Alcohol Use	☐ Occasional ☐ Moderate ☐ Heavy	
Recreational Drugs	☐ No ☐ Yes (Specify)	
Caffeine	[ ] Times per week	
Exercise Routine	[ ] Times per week	
Sleep	[ ] Hours a night	

Any Social Detriments to Health? ☐ No ☐ Yes *(describe)* _____

Occupation:	Living Situation: ☐ With roommates ☐ With S/O ☐ With family ☐Other: _____

Review of Systems *(Check any symptoms that you are experiencing)*

General	*EENT*	*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*	*Genitourinary*
☐ Shortness of breath ☐ Chronic cough ☐ Wheezing	☐ Abdominal pain ☐ Nausea or vomiting ☐ Diarrhea or constipation	☐ Incontinence ☐ Burning ☐Urgency ☐Frequency ☐Blood in urine
Musculoskeletal	*Psychiatric*	*Neurological*
☐ Joint pain or stiffness ☐ Muscle weakness ☐ Back pain	☐ Depression or feeling down ☐ Anxiety or panic attacks ☐ Sleep disturbances (insomnia, nightmares)	☐ Headaches or migraines ☐ Dizziness or lightheadedness ☐ Numbness or tingling

Additional notes:

Patient name:	Date:
Patient signature:	Date: