Medical History Form

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	**Previous or referring doctor:**
☐ yes ☐ no Tobacco use? What? How much?	
☐ yes ☐ no Alcohol use? What? How much? Other drug use?	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:	☐ Tetanus	☐ Hepatitis	☐ Pneumonia	☐ Influenza
	☐ MMR *Measles, Mumps, Rubella*		☐ Chickenpox	

List any medical problems that other doctors have diagnosed in the blank space below:

Have you ever had any of the following:

Asthma	Yes ☐	No ☐	High blood pressure	Yes ☐	No ☐
Blood clots	Yes ☐	No ☐	Kidney disease	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Liver disease	Yes ☐	No ☐
Chronic bronchitis or emphysema	Yes ☐	No ☐	Lupus or rheumatoid arthritis	Yes ☐	No ☐
Depression	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Thyroid disease	Yes ☐	No ☐
Heart disease	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Heart murmur	Yes ☐	No ☐	Ulcers	Yes ☐	No ☐

Surgeries/Hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had