Medical History

Name: _____ DOB: _____ Date: _____

Reason for visit: 1) _____

2) _____

Drug Allergies		

Family History use ✓ to indicate positive history								When was your last:	
	Self	Father	Mother	Sisters	Brothers	Daughters	Sons		
Deceased								Vaccines	
Hypertension								Pneumonia	
Diabetes								Flu	
Heart Disease								Tetanus	
Stroke								Mammogram	
Kidney Disease								Colonoscopy	
Obesity								Bone Density	
Glaucoma								Dilated Eye Exam	
Liver Disease								Pap Smear	
Depression or Bipolar Disorder								**Impairments**	
Colon or Rectal Cancer									
Breast Cancer									
Other Cancer									
Other_____									

Chronic Medical Problems		Medication List
Asthma		Rx meds, dose, frequency, route, Herbals, supplements, OTC drugs
Blood Clots		
Blood Transfusion		
Cancer		
Chronic Lung Disease		
Depression		
Diabetes		
Diverticulosis		
Heart Disease		
Hypertension		
Kidney Stones		
Gout		
Pneumonia		
Stroke		
Thyroid Problem		
Stomach Ulcers		

More on back ➔

Name: _____ DOB: _____ Date: _____

Hospital Admissions		Other Physicians You See
Date	Illness or Operation	Name

Social History

Work Status: _____ Occupation: _____

Alcohol ☐ no ☐ yes _____ oz. per week.

Smoking ☐ no ☐ former smoker, yr quit _____ ☐ yes _____ cig. per day

Female Menstrual History

Age of onset _____ Regular ☐ Irregular ☐ Last Menstrual Period _____

Menstrual Flow ☐ Heavy ☐ Moderate ☐ Light. Days of Flow_____. Cycle Interval_____.

Birth Control ☐ yes ☐ no. Birth Control Method _____. Menopause ☐ yes ☐ no.

# of Pregnancies_____ # of Live Births_____ #of Miscarriages_____ # of Living Children _____

Ethnicity	
Hispanic or Latino	Yes No

Language Spoken	
English	
Spanish	
Vietnamese	
Other	