MEDICAL HISTORY

Name ________________________________ **Age** ______ **Birthdate** ___/___/_____

Phone: Please indicate your preferred contact number by checking the appropriate box.

☐ **Home** _________________________ ☐ **Work** __________________________

☐ **Cell** ___________________________ ☐ **Email** ___________________________________

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Children: Please list names and ages.

____

____

☐ **Established Patient** ☐ **New Patient**

Pharmacy(s)

Name	Address

Past Medical History

Please indicate if you have/had any of the following conditions:

☐ Acid Reflux
☐ Alcohol Abuse
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Cancer (Type________________)
☐ Chronic Bronchitis
☐ Congestive Heart Failure
☐ COPD
☐ Depression
☐ Diabetes (Please circle: Type I or II)
☐ Emphysema
☐ Gout
☐ Heart Disease
☐ Heartburn
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Migraines
☐ Severe Headaches
☐ Sexually Transmitted Disease
☐ Stroke
☐ Thyroid problems
☐ Tobacco Use
☐ Tuberculosis
☐ Other ______________________________

Surgical History

Please list any surgeries and the year they occurred.

Surgery/Year	Surgery/Year

NOTE: This form is not part of the medical record. Shred 30 days after entered into the EHR.

Allergies

Do you have any allergies to medications, IV dyes, or other substances? ☐ Yes ☐ No
If 'yes,' please list them below and tell us your reaction.

Medication/Substance	Reaction
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Family History

Please indicate if a blood relative (parents, grandparents, siblings, children) has/ had any of the following conditions. Please list the type of relative in the right column.

	Blood Relative
Alcohol Abuse……	______________________________
Anxiety……	______________________________
Arthritis……	______________________________
Asthma……	______________________________
Cancer (Type_______________)……	______________________________
Congestive Heart Failure……	______________________________
COPD……	______________________________
Depression……	______________________________
Diabetes (Type ____)……	______________________________
GERD……	______________________________
GI problems……	______________________________
Gout……	______________________________
Heart Disease……	______________________________
High Cholesterol……	______________________________
Hypertension……	______________________________
Kidney Disease……	______________________________
Migraines……	______________________________
Nicotine Dependence (Smoker)……	______________________________
Severe Headaches……	______________________________
Sexually Transmitted Disease……	______________________________
Stroke……	______________________________
Thyroid problems……	______________________________
Tuberculosis……	______________________________
Other ______________________________	

Please let us know…

Are you or have you ever been a victim of abuse or neglect? ______________________________

Do you use alcohol? ☐ Yes ☐ No Number of drinks/week? ____

Do you use, or have you ever used, recreational drugs? ☐ Yes ☐ No What type? ____________________

Do you exercise regularly? ____________ Number of times/week ____________________

Do you drink caffeine? ________________

Do you have an advanced directive? ☐ Yes ☐ No If No, would you like information on AD? ☐ Yes ☐ No

What is your occupation? ______________________

If you are retired, what was your occupation when you were working? ____________________

Are you currently unemployed? ________________________

Do you smoke? _______________ How many packs a day? _______ For how long? _________

____
Reviewer Signature/Date

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