

MEDICAL HISTORY FORM

PATIENT'S NAME: _____ DATE: _____

Medical Reason for visit today: _____ Height: _____ Weight: _____

1. Do you have any one of the following? Please check (✓) if the answer is yes.

- | | | | |
|-------------------------|-------|---|-------|
| a. Heart disease | _____ | g. Thyroid disease | _____ |
| b. High blood pressure | _____ | h. Reflux | _____ |
| c. Elevated cholesterol | _____ | i. Other medical problems (Please list) | _____ |
| d. Cancer | _____ | | _____ |
| e. Depression | _____ | | _____ |
| f. Diabetes | _____ | | _____ |

Other Medical Information: _____

2. Do you have a living will? Yes _____ No _____ Do you have Advanced Directives? Yes _____ No _____

3. Please list all your medications. Please include vitamins and any herbal substances.

	<u>Name</u>	<u>Dose</u>	<u>Frequency</u>
a.	_____		
b.	_____		
c.	_____		
d.	_____		
e.	_____		
f.	_____		

4. Are you allergic to any medications? Please list below with the reaction that happened.

5. What surgeries have you had?

6. Do you smoke? No _____ Yes _____ Amount _____ Did you ever smoke? _____

7. Do you drink alcohol? No _____ Yes _____ Amount _____

8. What is your occupation? _____

9. How many children do you have? _____ Do they have any medical problems? _____

10. Are your parents alive? _____ What medical problem do (did) they have? _____
