Medical History Form

Patient information			
First name:	Last name:		
Date of birth:	Gender:		
Section one			
Are you pregnant or trying to get pregnant?	☐ Yes	☐ No	☐ Not applicable
Are you taking oral contraceptives?	☐ Yes	☐ No	☐ Not applicable
Are you taking any medication?	☐ Yes	☐ No	
If yes, please explain:			
Do you use any tobacco?	☐ Yes	☐ No	
If yes, please explain how often and how long you have been using them:			
Do you use any controlled substances?	☐ Yes	☐ No	
If yes, please explain what types of substances you take, how often, and how long you have been taking them:			
Do you have any allergies?	☐ Yes	☐ No	
If yes, please explain what you are allergic to, and what the allergic reaction is like:			

Section two			
Do you have, or have you had, any of the following?			
☐ AIDS/HIV positive	☐ Cortisone medicine	☐ Hemophilia	☐ Psychiatric care
☐ Alzheimer's disease	☐ Diabetes	☐ Hepatitis A	☐ Radiation treatment
☐ Anemia	☐ Drug addiction	☐ Hepatitis B or C	☐ Renal dialysis
☐ Angina	☐ Easily winded	☐ Herpes	☐ Rheumatic fever
☐ Arthritis gout	☐ Emphysema	☐ High blood pressure	☐ Rheumatism
☐ Artificial heart valve	☐ Excessive bleeding	☐ High cholesterol	☐ Scarlet fever
☐ Artificial joint	☐ Excessive thirst	☐ Hives or rash	☐ Shingles
☐ Asthma	☐ Fainting/syncope	☐ Hypoglycemia	☐ Sickle cell disease
☐ Blood disease	☐ Frequent cough	☐ Irregular heartbeat	☐ Sinus trouble
☐ Blood transfusion	☐ Frequent diarrhea	☐ Kidney problems	☐ Stomach disease
☐ Breathing problem	☐ Frequent headaches	☐ Leukemia	☐ Stroke
☐ Bruise easily	☐ Genital herpes	☐ Liver disease	☐ Swelling of limbs
☐ Cancer	☐ Glaucoma	☐ Low blood pressure	☐ Thyroid disease
☐ Chemotherapy	☐ Hay fever	☐ Lung disease	☐ Tonsilitis
☐ Chest pain	☐ Heart attack/failure	☐ Mitral valve prolapse	☐ Tuberculosis
☐ Cold sores/fever blisters	☐ Heart murmur	☐ Osteoporosis	☐ Tumors or growths
☐ Congenital heart disease	☐ Heart pacemaker	☐ Pain in jaw joints	☐ Venereal disease
☐ Convulsions	☐ Heart trouble/disease	☐ Parathyroid disease	☐ Jaundice

Have you had any illness not listed above?	☐ Yes	☐ No
If yes, please explain:		
Additional comments:		

Section three

Please write in any medical condition or disease that has been in your family.

Disease	Family member(s)

Section four

Please list any past **surgeries**:

Month/Year	Reason	Hospital

Please list any other **hospitalization**:

Month/Year	Reason	Hospital

Section five

All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my (or patient's health). It is my responsibility to inform the healthcare providers of any changes in the medical status.

Parent or guardian name (if applicable):	Relationship to patient (if applicable):
Signature of patient, parent or guardian:	Date: