

Name: _____

Date of Birth: _____

Gender: M F

MEDICAL HISTORY

Date: _____

FAMILY HISTORY	If Living		If Deceased		Has any Blood Relative		
	Age	Health	Age at Death	Cause	ever had:	Please encircle	Who?
Father:					Cancer:	no yes	
Mother:					Heart Trouble	no yes	
Brother or Sister: 1.					Diabetes:	no yes	
2.					High Blood Pressure:	no yes	
3.					Kidney Disease:	no yes	
4.					Stroke:	no yes	
5.					Epilepsy:	no yes	
6.					Tuberculosis:	no yes	
Son or Daughter: 1.					Depression:	no yes	
2.					Suicide:	no yes	
3.					Bleeding Disorder:	no yes	
4.					Mental Health Issues:	no yes	
5.					Other:		
6.							

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person or agency except with your written authorization.

PERSONAL HISTORY

ILLNESSES: Have you ever had: (please encircle all answers no or yes)

SURGERIES:

Alcohol Trouble	no yes	Memory Loss	no yes	Accidents/Fractures	no yes
Anxiety	no yes	Migraine	no yes	If yes, please describe:	
Asthma	no yes	Mononucleosis	no yes		
Back Trouble	no yes	Mumps	no yes	Appendectomy	no yes
Bleeding Disorder	no yes	Nervous Breakdown	no yes	Back	no yes
Cancer	no yes	Peptic Ulcer	no yes	Breast	no yes
Chicken Pox	no yes	Polio	no yes	Cataract	no yes
Depression	no yes	Rheumatic Fever	no yes	Colon or Intestine	no yes
Diabetes	no yes	Scarlet Fever	no yes	Ear Tube Replacement	no yes
Epilepsy	no yes	Sexual Diseases	no yes	Gallbladder	no yes
Fainting Spells	no yes	Stomach Ulcer	no yes	Hernia	no yes
German Measles	no yes	Stroke	no yes	Hysterectomy	no yes
Glaucoma	no yes	Thyroid Trouble	no yes	Prostate	no yes
Heart Disease	no yes	Tuberculosis (T.B.)	no yes	Stomach	no yes
Heart Murmur	no yes	Urinary Tract Infection	no yes	Tonsillectomy	no yes
Hepatitis	no yes	Whooping Cough	no yes	Other Surgeries	no yes
High Blood Pressure	no yes	Other Illnesses	no yes	If yes, please describe:	
Kidney Trouble	no yes	If Yes, please describe:			
Lung Trouble	no yes				
Measles	no yes				

HABITS:

How much?

Tobacco no yes
 Alcohol no yes
 Drugs no yes
 Caffeine no yes
 Exercise no yes

ALLERGIES: Describe _____

SOCIAL HISTORY

Married no yes
 Widowed no yes

Single no yes
 Divorced no yes

BIRTH: (If applicable)

Weight _____
 APGAR _____
 Problems at birth _____

 Premature? no yes

FEEDING HISTORY: (If applicable)

Breast Feeding no yes
 Formula no yes
 Start of Solid Foods _____

CURRENT MEDICATIONS: (List by name)
