



Patient Medical History

Name FIRST MIDDLE INITIAL LAST Date of Birth

Were you referred by another provider? If so, by whom:

Reason for your visit today:

PATIENT MEDICAL HISTORY: Have you ever had or still have the following (Check for yes):

- Checkboxes for various medical conditions: AIDS, Alcoholism, Allergy Problems, Anemia, Arthritis, Asthma, Bell's Palsy, Birth Defects, Bladder Problems, Bleeding Problems, Cancer, Cholesterol Problems, Circulation Problems, Diabetes, Epilepsy, Glaucoma, Gout, Heart Problems, High Blood Pressure, HIV, Intestinal Problems, Kidney Problems, Liver Problems, Lung Problems, Meniere's Disease, Migraines, Mitral Valve Disorder, Mononucleosis, Nervousness, Neurological Problems, Sleep Apnea, Paralysis, Prostate Problems, Reflux Problems, Seizures, Sickle Cell, Sinus Problems, Sjogren's, Skin Problems, Stomach Problems, Stroke, Thyroid Problems, Tuberculosis, Vertigo.

Are you allergic to any medication? Yes No Please list:

Are you currently taking any medications? Yes No Please list & include dosage (use back of this page if more space needed):

If you are 65 or older have you had a pneumonia vaccine? Yes No If Yes, when (if known)

Have you had a flu vaccine this year? Yes No If Yes, please list date (if known)

Do you have an Advance Directive or Living Will? Yes No

Are you pregnant? Yes No if yes, due date? and/or breastfeeding? Yes No

PAST SURGICAL HISTORY

Please list any past surgical procedures:

FAMILY HISTORY: Have any immediate blood relatives had the following? (specify relation, i.e. mother, etc):

- Checkboxes for family history conditions: Asthma, Bleeding Problems, Cancer, Diabetes, Epilepsy, Glaucoma, Heart Disease, High Blood Pressure, Stroke, Thyroid Problems, Tuberculosis.

SOCIAL HISTORY:

Tobacco Use (circle one): Current / Former / Never What type(s): Cigarettes / Cigars / Pipe / Snuff / Chew / Vape

How much/often? When did you: Start? Quit?

Alcohol Use: Yes No If Yes, how much and how often? Drug Use: Current / Former / Never

Signature: Date: