

MEDICAL HISTORY FORM

Name: _____ Birthdate _____ Sex: _____

Occupation: _____ **PERSONAL HISTORY** Married/Single _____

Please list current medications with exact dose and how often you take them: _____

_____ Why taken? _____

_____ Why taken? _____

_____ Why taken? _____

Prior Hospitalizations and Surgeries: (Include Date/Reason)

Allergies: (List name of drug and what happens to you)

Are you right or left handed? _____

Do you smoke? _____ Packs per day: _____ How many years? _____

Do you drink alcoholic beverages? _____ How many drinks per week? _____

Do you drink caffeine beverages? _____ How many drinks per day _____

Have you received treatment for chemical dependence? _____

Have you received psychiatric or psychological therapy _____ When? _____

Are you currently on a special diet? _____ Why? _____

FAMILY HISTORY

Living	Age at Death	Current Medical Condition or Cause of Death
Mother: _____		
Father: _____		
No. Of Sisters/Brother: _____		
No. Of Sons/Daughters _____		

Have you or any blood relative had:

Relation to you

Meningitis _____ Polio: _____

Cancer: _____ Tuberculosis: _____

Diabetes: _____ Heart Trouble: _____

Stroke: _____ Migraine: _____

Epilepsy: _____ Mental Illness: _____

Arthritis: _____ Multiple Sclerosis: _____

Genetic Illness _____ Dementia: _____

Other: _____ Other _____

HAVE YOU RECENTLY EXPERIENCED:

Please circle appropriate response:

Venereal Disease	Yes	No
Chest Pain	Yes	No
Difficulty Breathing	Yes	No
Difficulty Swallowing	Yes	No
Change In Appetite	Yes	No
Weight Change	Yes	No
Double Vision	Yes	No
Loss of Vision	Yes	No
Spots Before Eyes	Yes	No
Dizziness	Yes	No
Earaches	Yes	No
Headaches	Yes	No
Change in Taste/smell	Yes	No
Difficulty Talking	Yes	No
Numbness	Yes	No
Where:_____		
Weakness	Yes	No
Where:_____		
Palpitations	Yes	No
High Blood Pressure	Yes	No
Difficulty Staying awake	Yes	No
Insomnia	Yes	No
Snoring	Yes	No
Jerking in Sleep	Yes	No
Constant Fatigue	Yes	No
Stomach Pain	Yes	No
Back Pain	Yes	No
Swelling of Joints	Yes	No
Skin Rash	Yes	No
Seizures	Yes	No
Fainting	Yes	No
Blood in Urine	Yes	No
Blood in Stools	Yes	No
Black Stools	Yes	No

Difficulty Controlling		
Bowel Movements	Yes	No
Loss of Control of		
bladder	Yes	No
Impotence	Yes	No
Anxiety	Yes	No
Nervousness	Yes	No
Depression	Yes	No
Trouble with Memory	Yes	No
Change in Personality	Yes	No
Diarrhea	Yes	No
Nausea	Yes	No
Vomiting	Yes	No

Women Only

Age at onset of Menstrual Cycle: _____

Regular Menstrual Cycle: Yes No

Headaches with Menstrual Cycle: Yes No

Do you take birth control pills: Yes No

How long have you taken? _____

Have you ever been pregnant: Yes No

Have you ever had a miscarriage: Yes No

Number of children born alive: _____

Any complications with pregnancies: _____

Children 12 and Under

Age child started sitting up: _____

Age child started walking: _____

Age child started talking: _____

Complications at birth: _____

Any problems with pregnancy or birth: _____
