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MEDICAL HISTORY FORM

Patient Name: ____________________________ DOB: _____________________

Today's Date: _________________

DO YOU CURRENTLY HAVE OR HAVE HAD A HISTORY OF THE FOLLOWING?

☐ Diabetes: with use of ☐Pills ☐Insulin
☐ High Blood pressure/Hypertension
☐ High Cholesterol/Hyperlipidemia
☐ Hypothyroidism
☐ Hyperthyroidism
☐ Atrial Fibrillation
☐ Insomnia
☐ Depression/Anxiety
☐ Obstructive sleep apnea
☐ Fibromyalgia
☐ Congestive Heart failure/CHF
☐ Asthma
☐ COPD
☐ Migraines/headaches
☐ Anemia
☐ GERD/reflux
☐ Stroke/CVA – any residual weakness
☐ Cirrhosis
☐ Hepatitis: ☐A ☐B ☐C
☐ Valley Fever/Coccidioidomycosis
☐ Incontinence
☐ Arthritis
☐ Cancer *(If so, check the box that applies to your type of cancer)*
☐ Brain ☐ Lung ☐ Kidney ☐ Bone ☐ Thyroid
☐ Prostate ☐ Uterine ☐ Breast ☐ Bladder ☐ Ovarian

SURGERIES/DATES:

□ Pacemaker/Defibrillator: ______________
□Tonsils removed/Tonsillectomy: ____________
□ Adenoids removed/Adenoidectomy: ____________
□Appendix removed/Appendectomy: __________
□ Gallbladder removed/Cholecystectomy: _________
□Abdominal surgery: ________________
□ Gastric Sleeve: ________________
□Gastric Bypass: ___________________
□ Prostate Removal/Prostatectomy__________
□ Cervical spine surgery: __________
□ Thoracic spine surgery: _____________
□ Lumbar spine surgery: ___________
□ Shoulder surgery- left/right __________
□ Wrist surgery- left/right __________
□ Finger surgery – left/right: _____________
□ Hip surgery – left/right: ______________
□ Knee surgery – left/right: ______________
□ Ankle surgery – left/right: ____________
□ Foot surgery – left/right _______________
□ Toe surgery – left right: ______________
□Ovaries removed/oophorectomy_________
□Uterus removed/Hysterectomy: _________
□C-section_____________
□CABG: ________________
□ Any other surgeries not listed above: ____
____

WOMEN:

LNMP/last normal menstrual period: _______ Date of last PAP: _______☐Normal ☐Abnormal ☐Biopsy
Number of pregnancies/Para: _____________ Number of live births/Gravida: ______________
Date of last Mammogram: _______________ ☐ Normal ☐ Abnormal
Form of contraceptive? __________________

PREVENTATIVE CARE WOMEN/MEN:

Date of last Bone scan/ DEXA Scan: _______________ Facility Name: ________________________
Date of last Colonoscopy: ______________________ Doctors Name: ________________________

VACCINE / DATE GIVEN:

Date of Flu vaccine: _______________________ Date of pneumonia vaccine: _____________
Date of Shingles Vaccine: __________________ Date of Tetanus/DTap/Adacel: ___________
Are you up to date with childhood vaccine? ☐ YES ☐ NO

SOCIAL HISTORY:

Any use tobacco product? ☐ YES ☐ NO If so, how many cigarettes per day? ________ ☐ CHEW
Any use of alcohol? ☐ YES ☐ NO If so, ☐ Daily ☐Weekly ☐ Socially (amount) ? ________
Any use of Marijuana? ☐ YES ☐ NO If so, ☐ Daily ☐Weekly ☐ Socially
Any use of recreational drugs? ☐YES ☐ NO *(Please list name of drug and how often)* __________________________

MEDICATIONS AND DOSE:

ALLERGIES AND REACTION'S TO MEDICATIONS/FOODS: