

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:	