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MEDICAL HISTORY

Patient Name_____Today's Date_____

Date of Birth_____Sex ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Current Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Student

Do you currently use any tobacco products? ☐ Yes ☐ No

If yes, what do you use: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless Other:_____

If yes, amount of use per day:_____

Do you currently drink alcoholic beverages? ☐ Yes ☐ No

If yes, how often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Do you currently use recreational drugs? ☐ Yes ☐ No

If yes, what drugs:_____

How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Current Medications

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

Allergies (foods, medications, plastics, etc.):_____

Other illnesses, surgeries, injuries, or hospitalizations since birth and their approximate date(s) of occurrence:

Have you been immunized? ☐ Yes ☐ No

If yes, for what illness or diseases:_____

Have you experienced any of the following major medical conditions (please check all that apply):

☐ AIDS/HIV	☐ Genetic Disorders	☐ Meningitis
☐ Arthritis	☐ Headaches	☐ Mumps
☐ Blood Disorders	☐ Head Injury	☐ Scarlet Fever
☐ Cancer	☐ Heart Problems	☐ Stroke
☐ Chicken Pox	☐ High Blood Pressure	☐ TMJ
☐ Depression	☐ High Fevers	☐ Typhoid
☐ Diabetes	☐ Influenza	☐ Vascular Problems
☐ Diphtheria	☐ Malaise	☐ Other_____
☐ Encephalitis	☐ Malaria	
☐ Fatigue	☐ Measles	

Please check the correct box for the following medical symptoms or conditions:

Eye problems (such as blurred or double vision, pain):	☐ Yes	☐ No
Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues):	☐ Yes	☐ No
Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations):	☐ Yes	☐ No
Respiratory issues (such as shortness of breath, cough, wheezing):	☐ Yes	☐ No
Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain):	☐ Yes	☐ No
Musculoskeletal issues (such as joint pain, swelling, recent trauma):	☐ Yes	☐ No
Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness):	☐ Yes	☐ No
Psychiatric issues (such as depression, anxiety, compulsions):	☐ Yes	☐ No
Endocrine symptoms (such as frequent urination, hot flashes):	☐ Yes	☐ No
Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands):	☐ Yes	☐ No
Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency):	☐ Yes	☐ No

Comments related to review of symptoms above:_____