SmartMED
DRIVE-THRU MEDICAL CARE

MEDICAL HISTORY

Patient Name: _____

Patient DOB: _____ Age: _____

Current Weight (lbs): _____ Height: _____

ALLERGIES: Please list all that apply.

_____
_____
_____
_____

MEDICATIONS: Please list all medications that you are taking, including prescribed and over-the-counter (such as vitamins).

_____
_____
_____
_____
_____
_____

ADDITIONAL INFORMATION:

Please list anything below that you feel is important to for us to know.

_____
_____
_____
_____
_____

YOUR MEDICAL HISTORY: Please check all of the following that apply.

- ☐ Alcohol Abuse
- ☐ Asthma
- ☐ Bronchitis
- ☐ Constipation
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Fainting Spells
- ☐ Frequent Urination
- ☐ Gout
- ☐ High Cholesterol
- ☐ Irregular Pulse
- ☐ Lung Disease
- ☐ Moodiness
- ☐ Palpitations
- ☐ Sleep Apnea
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Convulsions
- ☐ Diarrhea
- ☐ Eating Disorder
- ☐ Fatigue
- ☐ Gallbladder Disorder
- ☐ Headaches
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Mental Illness
- ☐ Nervousness
- ☐ Rashes
- ☐ Stroke
- ☐ Arthritis
- ☐ Bloody Stool
- ☐ Chest Pain
- ☐ Depression
- ☐ Dizzy Spells
- ☐ Epilepsy
- ☐ Food Allergies
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Insomnia
- ☐ Liver Disease
- ☐ Migraines
- ☐ Obesity
- ☐ Shortness of Breath
- ☐ Thyroid Disease

FAMILY MEDICAL HISTORY:

Please list family members that have the past medical history and their relationship to you.

Kidney Disease: _____

Thyroid Disease: _____

Cancer: _____