



Medical History Form

Patient Name: _____ DOB: ____/____/____ Date: ____/____/____

Preferred Pronouns: _____ Preferred Pharmacy: _____

MEDICATIONS: *Please list all prescription and non-prescription medicines*

ALLERGIES: *List all medicines, foods and other agents.*

Medication Name	Dose	Frequency

Medication/Food	Reaction or Side Affect

PERSONAL MEDICAL HISTORY: *Please circle whether you have had any of the following medical problem*

Congenital Heart Disease: *please specify:* _____

Myocardial Infarction(Heart Attack)

Hypertension (High Blood Pressure)

Diabetes

High Cholesterol

Cancer (Malignancy)

please specify: _____

Stroke

Coagulation (Bleeding/Clotting)

Depression/Suicide Attempt

Alcoholism

Hepatitis A, B, or C (*specify*) _____

Date of Last Colonoscopy: _____

Date of last Tetanus Shot: _____

Date of last HIV Test: _____

Date of Blood Transfusion: _____

Other: _____

SURGICAL HISTORY: *Please list all prior surgeries and dates.*

Surgery	Date

WOMEN'S HEALTHY GYNECOLOGIC/OBSTETRIC HISTORY: *(For Women Only)*

of Pregnancies: ____ # of Deliveries: ____ # of Abortions: ____ # of Miscarriages: ____ Age at 1st menses: ____ Frequency of

menses: _____ Length of menses: _____ Date of last menses: _____ Date of last mammogram: _____

Do you have any concerns about your period or menopause? ☐ Yes ☐ No Please explain: _____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No If circled yes, when was it? _____

FAMILY HISTORY: Please indicate with a check (✓) who in your family has had the following conditions. In the first column please indicate their living status. L = Living, D = Deceased, U = Unknown.

	Living Status	Asthma	Diabetes	High Blood Pressure	Heart Disease	Stroke	Heart Attack	Cancer (Type)	Colon Polyps	Depression	Other
Mother											
Father											
Siblings											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											
Other Family Members Information: (please write in)											

SOCIAL HISTORY:

Exercise:

Do you exercise regularly? ☐ Yes ☐ No

Tobacco Use:

☐ Current ☐ Never ☐ Former: quit on: _____

*If current # of packs/day _____ # of years _____

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ No ☐ Yes

Drug Use:

Do you use any recreational drugs?

☐ Yes ☐ No

If yes please list _____

If you have used in the past, how long have you been drug free? _____ Have you ever used needles for IV drug use? ☐

Yes ☐ No ☐

Alcohol Use:

Do you drink alcohol? ☐ Yes ☐ No If yes, # of drinks per week: _____ What type of alcohol: _____ Is

alcohol a concern for you or others who surround themselves around you? ☐ Yes ☐ No

SAFETY SOCIOECONOMICS

Do you wear a seatbelt regularly? ☐ Yes ☐ No

Do you wear a bike helmet regularly? ☐ Yes

☐ No

Do you feel safe at home? ☐ Yes ☐ No Do you

feel safe in your current relationship? ☐ Yes

☐ No

Have you ever been physically or sexually abused? ☐ Yes ☐ No

Do you have a gun in your home?

☐ Yes ☐ No

Occupation: _____

Marital Status: _____

Spouse/Partner's Name: _____

Who lives at home with you? _____

MENTAL HEALTH

In the past year, have you had 2 or more weeks during which you felt sad or depressed; or you lost all interest or pleasure in things that you usually cared about or enjoyed? ☐ Yes ☐ No

Have you felt down, depressed or hopeless in the past 2 weeks? ☐ Yes ☐ No

Do you ever feel like hurting yourself or others? ☐ Yes ☐ No