Patient Medical History Form

Full Name: _____
Date of Birth (mm/dd/yyyy): _____

Family Medical History

1. Hereditary diseases in the family: _____
2. Family history of (Check if applicable and indicate affected family member):

□ Heart Disease Family member:_____

□ Diabetes Family member:_____

□ High Blood Pressure Family member:_____

□ ADHD Family member:_____

□ Schizophrenia Family member:_____

□ Bipolar Family member:_____

□ Other _____

Lifestyle

1. Smoker? □ Yes □ No Age started_____
2. Do you drink alcohol? □ Yes □ No. Preferred drink_____
3. How many days per week do you exercise? _____
4. Any dietary restrictions? □ Yes □ No
5. If yes, please specify: _____

Growth & Development

1. Born as a full term baby? □ Yes □ No
2. Puberty started at typical age? □ Yes □ No □ Pre-puberty
3. Females – Age when experienced first period: _____

Consent

I hereby consent to share the above information for the purpose of medical treatment and understand that this information will be kept confidential.

Signature: _____ Date: _____

NOTE: If the patient is under 18, a parent or guardian must sign.