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Medical History Form

(Please complete entire form before your visit)

Patient Name: ______________________ Date of Birth: ______________________

Occupation: ______________________ Primary Care Physican: ______________________

Date of last medical examination: ______________________ Marital/Partner Status: ______________________

Personal History:

Allergies to medications:

____

____

____

Medications:

____

____

____

Hospitalizations & Surgeries:

____

____

____

Personal & Family History:

If applicable, please name WHO had problem and approximate AGE at onset if known. (Self, parents, children, brothers, sisters, aunts, uncles)

	SELF	WHO	AGE
If deceased, age at death:			
Alcoholism:			
Anemia:			
Asthma:			
Cancer or Tumor:			
Diabetes:			
Epilepsy:			
Heart Problems:			
High Blood Pressure:			

Mental Illness: ______ ______ ______
Depression: ______ ______ ______
Rheumatism/Arthritis: ______ ______ ______
Stroke: ______ ______ ______
Thyroid Problem: ______ ______ ______
Other: ______ ______ ______

Please list any other problems you are having at this time:

______
______
______

Personal Habits:

Exercise: (Type and how often)

______

Work: ______ Hours/Day:______ In or Outdoors? ______

Do you enjoy your work? ___Yes ___No

Participate in Sports/Hobbies: ___Yes ___No

Caffeine? (coffee, soda) ___Yes ___No

Number of hours you sleep at night:______

Any safety issues at home? ___Yes ___No

Ever been treated for drug abuse? ___Yes ___No

Alcoholic beverages: ___Yes ___No

If yes, how many drinks daily?______

Ever used 'recreational drugs? ___Yes ___No

If yes, how often, what type, last date?______

______

Tobacco: Cigarettes: ___ Cigars: ___ Pipe: ___ Chewing Tobacco : ___

If you have smoked in the past, when did you quit? : ______

Due to some medications that have been shown to cause bowel and bladder issues in some patients, please answer "yes" or "no" for the following questions:

Have you had any recent bowel movement problems? (This includes diarrhea or constipation) ___Yes ___No

Any recent problems with urination? ___Yes ___No

Thoughts that you would be better off dead, or hurting yourself in some way? (Please circle selected answer)

1. Not at All 2. Several Days 3. More than half the days 4. Nearly every day

Patient's Signature: ______ Date: ______