imprint

Patient Medical History

Patient Name

____
FIRST MIDDLE LAST

Address

____
CITY, STATE, ZIP

Date Form Completed: ______________

Phone: Home AREA CODE ( ) ______________

Business AREA CODE ( ) ______________

Emergency AREA CODE ( ) ______________

Sex: ☐M ☐F

Birthdate ______________
Month Day Year

Were you sent here by a physician? Yes______ No______

Physician's name ______________

Do you want your records sent to him/her? Yes _____ No _____

Physician's address ______________

Past Medical History: Please check which of the following problems you have had, and if possible, indicate the year.

- ☐ Heart disease ______________
- ☐ Diabetes ______________
- ☐ High blood pressure ______________
- ☐ Cancer (where, kind) ______________
- ☐ Ulcer ______________
- ☐ Lung disease ______________
- ☐ Kidney disease ______________
- ☐ Thyroid disease ______________
- ☐ Blood disorder ______________
- ☐ Anemia ______________
- ☐ Tuberculosis ______________
- ☐ Seizure ______________
- ☐ Allergy ______________
- ☐ Asthma ______________
- ☐ Meningitis ______________
- ☐ Encephalitis ______________
- ☐ Phlebitis ______________
- ☐ Rheumatic heart disease ______________
- ☐ Liver disease (hepatitis, cirrhosis) ______________
- ☐ Other (specify) ______________

Have you ever had:

Blood Transfusions ☐ Yes ☐ No If yes, when? ______________ Was there a reaction? ______________

DRUG ALLERGY ☐ Yes ☐ No If yes, answer:

Name of drug(s)	Date of reaction	Describe reaction

DRUG INTOLERANCE ☐ Yes ☐ No If yes, answer:

Name of drug(s)	Date of reaction	Describe reaction

Steroid Therapy (Cortisone) ☐ Yes ☐ No If yes, when?________

Immunizations: **Rubella (German Measles)** ☐ Yes ☐ No

Whooping Cough ☐ Yes ☐ No

Typhoid ☐ Yes ☐ No

Tetanus ☐ Yes ☐ No **(List year__________)**

Polio ☐ Yes ☐ No

Diptheria ☐ Yes ☐ No

Please list the medications you are currently taking (including birth control pills):

NAME	DOSAGE	WHEN DID YOU START THE MEDICINE?

Menstrual History:

At what age did you start menstruating? ______________ Last menstrual period ______________

Last pap smear ______________ # of pregnancies ______________ # of miscarriages ______________

# of abortions ______________ Do you have any menstrual problems? ______________

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PLEASE TURN OVER AND FILL OUT BACK OF FORM

Please list past **MAJOR HOSPITALIZATIONS** including surgery. Do not list pregnancy unless you had a Cesarean Section or complications.

YEAR	PLACE	ILLNESS/OPERATION	DOCTOR

Please list other past major illnesses/injuries:

YEAR	ILLNESS/INJURY

Patient's Social History:

Occupation ________ Currently employed? ☐Yes ☐No

Education (Highest level completed) ________ Place of Birth ________ Religion ________

Habits: Tobacco ☐Yes ☐No If yes, number of packs per day? ________ How many years? ________

Coffee/Tea ☐Yes ☐No How many cups per day? ________

Alcohol ☐Yes ☐No How much in usual week (drinks or bottles of beer)? ________

Sleep: Approximate number of hours/night ________

Married ☐Yes ☐No Spouse: Age ________ Occupation ________