MEDICAL HISTORY FORM

Date of Visit_____

Last Name_____First Name_____ Age_____Date of Birth_____

Current Medications			
Please list prescription medications, over the counter medications, vitamins and supplements.			
Name of Medicine	Dosage	How Often	Reason

Medical History/Major Illnesses	
Year	Problem

Allergies	
Allergies	Reaction

Surgical History	
Year	Type of Surgery

Hospitalization	
Year	Reason

Family History	
Family Member	**Medical History**
Father ☐ Alive Age_____ ☐ Deceased	
Mother ☐ Alive Age_____ ☐ Deceased	
Paternal Grandfather ☐ Alive ☐ Deceased	
Paternal Grandmother ☐ Alive ☐ Deceased	
Maternal Grandfather ☐ Alive ☐ Deceased	
Maternal Grandmother ☐ Alive ☐ Deceased	
Please specify if your other blood relatives (*eg. siblings, uncles, aunts etc)* have any medical illnesses.	
Relationship	**Medical Illness**

Immunizations		
Please check the box if you had the following vaccination in the past.		
Name of Vaccine	**Yes**	**Date last given**
Tdap/Tetanus	☐	
Flu shot	☐	
Pneumonia shot	☐	
Zostavax or Shingrix	☐	
HPV shot	☐	
Hepatitis A	☐	
Hepatitis B	☐	
PPD (tuberculosis)	☐	

Social History			
Habits	**Yes**	**No**	**Details**
Have you ever smoked?	☐	☐	When started: Packs per day: When quit:
Do you smoke now?	☐	☐	Packs per day:
Alcohol	☐	☐	Drinks per week:
Caffeine	☐	☐	Cups per day:
Drug Use	☐	☐	Type:

Have you done the following exams before?			
Exam type	**Yes**	**No**	**Date of last exam**
Colonoscopy	☐	☐	
Bone Density/DEXA scan	☐	☐	
HIV testing	☐	☐	
Men only: Prostate Specific Antigen (PSA)	☐	☐	

Other Medical Providers	
List any other medical or alternative providers by name and specialty/reason that you see them.	
Specialty/Reason	Name

Gynecologic History (FEMALE PATIENTS ONLY)	
Date of last period	
Is your period regular?	Yes ☐ No ☐
How many days does your period last?	
Do you use more than 5 pads/ tampons on your heaviest day?	Yes ☐ No ☐ N/A ☐
Do you have history of low iron or anemia?	Yes ☐ No ☐
Are you currently taking birth control pills?	Yes ☐ No ☐ Other:
Date of last pap smear : History of abnormal pap : Yes ☐ No ☐	
Date of last mammogram : History of abnormal mammogram : Yes ☐ No ☐	
Have you ever been pregnant? : Yes ☐ No ☐ *If yes, please answer below:* # Pregnancy___ # Term Birth___ # Pre-term Birth___ # Miscarriages___ # Abortions___ # Living Children___	