



Date _____

Age _____

Please complete the following **Medical History** form prior to seeing the doctor or PA.
(Feel free to use the back side for more space for your answers)

Name: _____ record number: _____

Reason for visit: _____ Injury Date: _____

How long has this been going on? _____ Pharmacy: _____

What medicine have you taken for this problem? _____

Name of family/medical doctor: _____ Did he/she refer you for this problem? _____

List all medical problems for which you take medicine: _____

List ALL current medicines (include over-the-counter medicines):

Social History:

Do you drink alcohol? Yes__ No__. If yes, how much per day/week? _____

Do you use tobacco? Yes__ No__. If yes, what type, and how much? _____

Marital Status: Single__ Married__ Divorced__ Widowed__

Living situation: Alone __ With Spouse __ With Relative__ If with relative indicate who: _____ Nursing Home: (Indicate Name) _____

Employer: _____

What type of work, if any, do you do? (Indicate if disabled or retired) _____

Family History:

Do any diseases run in your family? If so, please list them. _____

Are your parents living? Yes__ No__. Age and cause of death: _____

Allergies: Do you have allergies to any medications? ____ List them: _____

Operations: All past surgeries / operations: _____

What is your current height? _____ What is your current weight? _____

Have you ever had a Bone Density test/ scan? _____

If yes, date of most recent scan: _____ Please see reverse side ⇨

Review of Systems: (only positives are checked)

- | | | | |
|---------------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Shortness of | <input type="checkbox"/> Varicose | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Chills | Breath | Veins | Problem |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Tingling in |
| <input type="checkbox"/> Wears | <input type="checkbox"/> Nausea | <input type="checkbox"/> Skin Rash | Feet |
| Glasses | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Eczema | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Anxiety |
| Changes | <input type="checkbox"/> Heart | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Asthma | Murmur | <input type="checkbox"/> Anemia | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Double | <input type="checkbox"/> Sensitive | <input type="checkbox"/> Swollen | <input type="checkbox"/> Steroid Use |
| Vision | Stomach | Glands | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Painful | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Hearing Aid | Urination | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Blood in | <input type="checkbox"/> Goiter | <input type="checkbox"/> None of the |
| <input type="checkbox"/> Runny Nose | Urine | <input type="checkbox"/> AIDS/HIV | Above |
| <input type="checkbox"/> Nosebleed | <input type="checkbox"/> Bladder | <input type="checkbox"/> Bad Nerves | |
| <input type="checkbox"/> Chest Pain | Infection | <input type="checkbox"/> Sleep Apnea | |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Diabetes | |

