# Medical History Form

Patient's First Name _____ Middle Initial _____ Last Name _____
Are you currently under the care of a physician? ❑ No ❑ Yes
For what reason: _____
When was your last physical exam? _____
Physician's Name _____ Pharmacy Phone #: _____
Address _____ Phone _____ Last Time seen _____
Have you ever been hospitalized? ❑ No ❑ Yes
List All With Dates _____
Are you taking any prescription medication? ❑ No ❑ Yes
List All _____

_____

Are you taking any over the counter medication? ❑ No ❑ Yes
List All With Dates _____
Are you allergic to any medications or substances? ❑ No ❑ Yes
If yes, please explain _____
Do you take appetite suppressants? ❑ No ❑ Yes Name of product: _____

## Have you ever had any of the following diseases or medical conditions? (Check Yes or No)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ❑ No ❑ Yes | Heart Attack/Stroke | ❑ No ❑ Yes | Epilepsy | ❑ No ❑ Yes | Osteoporosis |
| ❑ No ❑ Yes | Cancer/Chemotherapy | ❑ No ❑ Yes | Seizures | ❑ No ❑ Yes | Atrial Fibrillation |
| ❑ No ❑ Yes | Heart Murmur | ❑ No ❑ Yes | Fainting | | |
| ❑ No ❑ Yes | Rheumatic Fever | ❑ No ❑ Yes | Diabetes | | |
| ❑ No ❑ Yes | HIV/AIDS | ❑ No ❑ Yes | Tuberculosis | **If Diabetic:** | |
| ❑ No ❑ Yes | Hepatitis A | ❑ No ❑ Yes | Hemophilia | Last Blood Sugar Reading _____ | |
| ❑ No ❑ Yes | Hepatitis B | ❑ No ❑ Yes | Blood Transfusion | Last Blood Sugar Date _____ | |
| ❑ No ❑ Yes | Hepatitis C | ❑ No ❑ Yes | High Blood Pressure | Last $A_1C$ _____ | |
| ❑ No ❑ Yes | Hepatitis D | ❑ No ❑ Yes | Low Blood Pressure | Last $A_1C$ Date _____ | |
| ❑ No ❑ Yes | Anemia | ❑ No ❑ Yes | Radiation Treatment | | |
| ❑ No ❑ Yes | Mitral Valve Prolapse | ❑ No ❑ Yes | Kidney Problems | | |
| ❑ No ❑ Yes | Artificial Joints | ❑ No ❑ Yes | Artificial Heart Valves | | |
| ❑ No ❑ Yes | Sinus Problems | ❑ No ❑ Yes | Severe Headaches | | |
| ❑ No ❑ Yes | Asthma | ❑ No ❑ Yes | Frequent Headaches | | |
| ❑ No ❑ Yes | Difficulty Breathing | ❑ No ❑ Yes | Emphysema | | |
| ❑ No ❑ Yes | Venereal Disease | ❑ No ❑ Yes | Shingles | | |
| ❑ No ❑ Yes | Herpes Type I | ❑ No ❑ Yes | Herpes Type II | | |
| ❑ No ❑ Yes | Heart Surgery | ❑ No ❑ Yes | Pacemaker | | |
| ❑ No ❑ Yes | Psychiatric Problems | ❑ No ❑ Yes | Glaucoma | | |
| ❑ No ❑ Yes | Do You Smoke? | ❑ No ❑ Yes | Do you Consume Alcohol? | | |

## Are You Allergic To Any of the Following?

| | | | |
|---|---|---|---|
| ❑ No ❑ Yes | Penicillin | ❑ No ❑ Yes | Codeine |
| ❑ No ❑ Yes | Aspirin | ❑ No ❑ Yes | Tetracycline |
| ❑ No ❑ Yes | Erythromycin | ❑ No ❑ Yes | Germicides/Pesticides |
| ❑ No ❑ Yes | Latex/or Rubber Products | ❑ No ❑ Yes | Other _____ |

## For Women Only:

| | | | |
|---|---|---|---|
| ❑ No ❑ Yes | Taking Birth Control Pills | ❑ No ❑ Yes | Pregnant/No. of Months: _____ |
| ❑ No ❑ Yes | Nursing? | ❑ No ❑ Yes | Hormone Therapy |

All information is true, correct, and complete to the best of my knowledge:

Signature _____ Date _____

# MEDICAL HISTORY FORM

REV 2/22/16