



MEDICAL HISTORY FORM

FORM **MUST** BE FILLED OUT PRIOR TO VISIT

Name: _____

Birthdate: _____

MR#: _____

History of Present Illness

What is the reason for your visit today:

Past Medical History

Please list current and past medical problems that you have been treated for:

- | | | | | |
|--|---|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Allergy or Asthma | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Reaction to Anesthetic | | | |

Illness or Medical Problem	Physician who Treated you

Past Surgical History

Surgery	Hospital	Year

Current Medications

Please list all medications you are now taking, including those you buy without a doctor's prescription (such as aspirin, cold tablets, nutritional supplements, and/or herbal medicines)

Name	Strength	Frequency

Allergies and Sensitivities

List any allergies to medications or foods that you may have and indicate how each affects you.

Allergic To	Reaction

No known drug allergies