Medical History Form

Date of Visit:________________

Patient Name:________________________________ Date of Birth:_________________

Family History:

(Please circle those that apply. Indicate relationship to patient.)

Hypertension (high blood pressure)

Myocardial infarction (heart attack)

Cerebrovascular accident (stroke)

High cholesterol

Heart disease

Diabetes

Hypothyroid (low thyroid)

Hyperthyroid (high thyroid)

Hashimoto's thyroiditis

Grave's disease

Kidney stones

Polycystic kidneys

Blood clots

Factor V Leiden

Hemophilia

MTHFR

Breast cancer

Prostate cancer

Colon cancer

Lymphoma

Lung cancer

Brain Tumor

Rheumatoid arthritis

Lupus

Scleroderma

Asthma

COPD/emphysema

Seizures

Migraine

Bipolar

ADHD

Depression

Other:____

____

____

Medical History Form

Date of Visit:_______________

Patient Name:______________________________ Date Of Birth:________________

Health history:

Current Problems:____

Past Problems:____

Hospitalizations (approx date):____

____

Surgeries (approx date):____

____

Medications:____

____

Allergies:____

Social History:

Who lives at home:____

____

Smoke detector: Y N

Pool/pond/lake near home: Y N

Second hand smoke: Y N

Pets:___________________

Carbon monoxide detectors: Y N

Firearms in home: Y N

Daycare: Y N

Water: City Well