MEDICAL HISTORY FORM – Pg. 2

LIST ALL MEDICATIONS YOU TAKE (include vitamins, birth control pills, aspirin, health food, etc.): Use additional sheet if needed.

Medication	Dose (mg)	How Often?

DO YOU HAVE ANY ALLERGIES? ☐ Yes ☐ No (If YES, to what and what is your reaction?)

_____

_____

DO YOU USE TOBACCO? ☐ Yes ☐ No DETAILS: Cigarettes (how many and how long), cigars, pipe, chewing tobacco _____

_____

DO YOU OR HAVE YOU USED ALCOHOL OTHER THAN SOCIALLY? ☐ Yes ☐ No (If YES, how much and what type?) _____

_____

CURRENT OR PAST RECREATIONAL DRUG USE? (Narcotics, Marijuana, Cocaine, Heroin, others) ☐ Yes ☐ No

_____

ARE YOU CURRENTLY MARRIED ☐ DIVORCED ☐ SEPARATED ☐ SINGLE, NEVER MARRIED ☐ (provide details)

_____

OCCUPATION: (Past) _____

(Present) _____

FAMILY HISTORY:

	AGE	LIVING/DECEASED	STATE OF HEALTH/CAUSE OF DEATH
MOTHER	_____	_____ / _____	_____
FATHER	_____	_____ / _____	_____
BROTHERS	_____	_____ / _____	_____
	_____	_____ / _____	_____
SISTERS	_____	_____ / _____	_____
	_____	_____ / _____	_____
CHILDREN	_____	_____ / _____	_____
	_____	_____ / _____	_____

WHAT ILLNESSES RUN IN YOUR FAMILY? (diabetes, kidney stones, prostate or other cancer, bladder/kidney problems, etc.)

_____

NOTES: (for office use only)