MEDICAL HISTORY

Date filled out ___________________

Age when filled out_______________

PERSONAL DATA

Name ____ Sex: M F Marital Status: M S D Sep

Address ____ Birthdate _______________ Birthplace _______________________

____ Religion ________________ Education _______________________

Phone: Home ________________ Work ________________ Employer & Occupation ______________________________________

Cell # ______________________ Race ________________ Emergency Contact: _____________________________________

HOME INFORMATION

Are you living in a: ☐ Fixed Residence ☐ Homeless Shelter

☐ Transitional Housing ☐ Doubling Up With Friends/Family

Do you rely on well water? ☐ Yes ☐ No

List all people living with you:

Name	Age	Relationship	Health

PERSONAL HEALTH

General Health: ☐ Good ☐ Fair ☐ Poor

Allergies (list drugs, food, etc.) ____

Medications:

Name	Dose	How Often	Name	Dose	How Often

List previous hospitalizations or surgeries: (if many, the 6 most recent)

	When	Where	Reason		When	Where	Reason
1.				4.			
2.				5.			
3.				6.			

Major accidents and injuries ____

Immunization - Year ____

Tetanus _____ Flu _____ Pneumonia _____

LIFESTYLE

Do you Smoke? ☐ Yes ☐ No _______ packs/day for ________ years. If you quit, list when ___________________________

Do you drink alcohol? ☐ Yes ☐ No What kind, how much, and how often? ____

Do you use other drugs (such as Marijuana)? ☐ Yes ☐ No What kind, how much? _______________________________

When was your last dental checkup? _____________

FAMILY HISTORY

	Name	Age	Health
Father			
Mother			
Brothers			
Sisters			
Spouse			
Children			

Does the patient or any blood relative have:

	Patient		Relative			Patient		Relative	
	Yes	No	Yes	No		Yes	No	Yes	No
Heart Disease	☐	☐	☐	☐	High Cholesterol	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	Convulsions	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	Stroke	☐	☐	☐	☐
Depression	☐	☐	☐	☐	Alcoholism	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Emotional Problems	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Learning or				
Kidney Disease	☐	☐	☐	☐	Speech Problems	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	Other Family Problems	☐	☐	☐	☐

Describe: ____

____

WOMEN

Total number of Pregnancies? _________

Number of live births? __________

Number of miscarriages or abortions? _________

How frequent are your periods? Every ____ days.

Lasting ___________ days.

Describe your menses (normal, light, painful): ____________

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THANK YOU FOR YOUR HELP