

**Confidential Medical History Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies Have you ever had an allergic reaction? ☐ Yes ☐ No

Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Allergies (latex, bee stings, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all medications, vitamins, supplements (attach list if needed)

|  |  |  |
| --- | --- | --- |
| Medication | Dosage | How often |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Does YOUR IMMEDIATE FAMILY have any of the following?**

☐ Adopted (Family history unknown)

**Please circle whether Mother, Father, Siblings or Grandparents have a history of the following:**

Alcoholism Blood Clots/Clotting Disorders Breast Cancer Colon Cancer Melanoma

Other Cancers (List Type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes Drug Dependency Heart Disease High Blood Pressure

High Cholesterol Mental Illness Stroke Sudden Cardiac Arrest (under age 50)

Other (Please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Deceased How did your parent die?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST/CURRENT PERSONAL MEDICAL HISTORY:**

**Have YOU EVER had any of the following?**

**Heart/Lungs:** ☐ Asthma ☐ Heart Disease (valve, vessel, rheumatic, etc.) ☐ Heart Murmur ☐ High Blood Pressure ☐ High Cholesterol ☐ Pneumonia

**Endocrine:**  ☐ Adrenal Disorders ☐ Diabetes ☐ Polycystic Ovary Syndrome (PCOS) ☐ Thyroid Disorder

**Kidney**: ☐ Chronic Kidney or Bladder Disease ☐ Kidney Stones

**Ears/Eyes/Nose/Throat:**  ☐ Chronic Sinus Infections ☐ Eye Disorders (other than glasses or contacts) ☐ Hearing Loss

☐ Nasal Allergies/Hayfever

**Stomach/Bowel**: ☐ Celiac Disease ☐ Irritable Bowel Syndrome ☐ Stomach/Duodenal Ulcers ☐ Ulcerative Colitis/Crohn’s ☐ Other Liver, Stomach, or Bowel Disease ☐ GERD

**Neurological**: ☐ Concussions ☐ Convulsions/Seizures ☐ Migraines/Severe Headaches ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Stroke/TIA ☐ Loss of memory

**Mental Health**: ☐ ADHD ☐ Alcohol Abuse ☐ Anorexia (Eating Disorder) ☐ Anxiety Disorder ☐ Bulimia (Eating Disorder) ☐ Depression ☐ Drug Dependency ☐ Other Mental Health Problems

**Hematology/Oncology**: ☐ Anemia ☐ Bleeding Disorders ☐ Blood Clots/Clotting Disorders ☐ Cancer ☐ Radiation Therapy

**OB/GYN**: ☐ Endometriosis ☐ Pregnancies #: \_\_\_\_\_ Other History ☐ When was your last menstrual period? \_\_\_\_\_\_\_\_

What are you using for birth control? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Orthopedics**: ☐ Arthritis ☐ Fractures/Broken Bones

**Infectious Diseases**: ☐ Chickenpox/Varicella ☐ Hepatitis Type: \_\_\_\_\_\_\_\_ ☐ HIV Infection ☐ Infectious Mononucleosis ☐ Malaria ☐ Mumps ☐ Tuberculosis ☐ Typhoid Fever

**Skin**: ☐ Eczema ☐ Psoriasis ☐ Hives

**STDs**: ☐ Chlamydia ☐ Genital Herpes ☐ Genital Warts ☐ Gonorrhea ☐ HPV ☐ Other STD

**Surgical History**: ☐ Appendectomy ☐ Adenoidectomy ☐ Ear Tubes ☐ Gallbladder Removal ☐ Knee ACL Repair L \_\_\_ R \_\_\_ ☐ Knee Arthroscopy L \_\_\_ R \_\_\_ ☐ Organ Transplant ☐ Ovarian Cyst Removal ☐ Splenectomy ☐ Tonsillectomy ☐ Weight Loss Surgery ☐ Other Prior Surgeries Social History

**Lifestyle:** Do you drink alcohol? \_\_\_\_\_\_\_ Amount and how often: \_\_\_\_\_\_\_\_\_\_ Do you exercise regularly? \_\_\_\_\_\_\_\_

Do you take recreational drugs? \_\_\_\_\_\_\_\_ Do you smoke? \_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_

Do you use smokeless tobacco? \_\_\_\_\_\_\_\_ How much? Are you interested in help with quitting? \_\_\_\_\_\_\_\_\_\_

Do you have guns in your home? \_\_\_\_\_\_\_\_ If so, are they kept locked up so children cannot access them? \_\_\_\_\_\_\_\_\_\_

Date of last preventive exam: \_\_\_\_\_\_\_\_\_\_ Date of last pap smear: \_\_\_\_\_\_\_\_\_\_ Date of last mammogram: \_\_\_\_\_\_\_\_\_\_

Date of last colonoscopy: \_\_\_\_\_\_\_\_\_\_ Date of last bone density scan: \_\_\_\_\_\_\_\_\_\_ Date of last eye exam: \_\_\_\_\_\_\_\_\_\_

Date of last dental exam: \_\_\_\_\_\_\_\_\_\_

Do you feel safe at home? \_\_\_\_\_\_\_\_ Do you feel safe in your current intimate relationship? \_\_\_\_\_\_\_\_

**When did you last have the following immunizations?**

Influenza \_\_\_\_\_\_\_\_\_\_\_ Chicken pox \_\_\_\_\_\_\_\_\_\_\_ Hepatitis B \_\_\_\_\_\_\_\_\_\_ Hepatitis A \_\_\_\_\_\_\_\_\_\_ MMR \_\_\_\_\_\_\_\_\_\_ Polio \_\_\_\_\_\_\_\_\_\_ Pneumonia \_\_\_\_\_\_\_\_\_\_ Shingles \_\_\_\_\_\_\_\_\_\_ tetanus (tD, tDap) \_\_\_\_\_\_\_\_\_\_

**Previous Hospitalizations**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER Health Problems:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the main reason you are here today?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**