Medical History Form

Date:_____ **Provider Initials:** _____

Do not scan until initialed

Demographics

Patient Name:_____
Date of Birth:_____
Sex: Female Male
Ethnicity:_____
Home#_____
Cell#_____
Work#_____

Social History

Adultôs residing in Home:_____

Siblings:

NAME	AGE	Health

Smokers in Home:_____
Pets in Home:_____

Allergies

Food Allergies: YES NO
Medication Allergies: YES NO
If yes, please explain:_____
_____

Past Medical History

Hospitalizations:	YES	NO	Asthma:	YES	NO
Emergency room visits:	YES	NO	Visual/Hearing Problems:	YES	NO
Fractures:	YES	NO	Heart Murmur:	YES	NO
Surgeries:	YES	NO	High Blood Pressure:	YES	NO
Birth Complications:	YES	NO	Developmental concerns:	YES	NO
Seasonal/Environmental Allergies:	YES	NO	Serious Injury/Illness:	YES	NO
Frequent Cough:	YES	NO	Diabetes:	YES	NO
Urinary/Kidney Problems:	YES	NO			

If answered yes, Pleas explain:_____
_____
_____
_____

Family Medical History

Are there any of the problems listed below in siblings of patient, parents, grandparents, aunts, uncles or cousins. Please write relation of person(s) with illness.

High Cholesterol:_____ Cancer:_____
Diabetes:_____ Tuberculosis:_____
Inherited Disorder:_____ Seizure Disorder_____
High Blood Pressure:_____ Developmental Delay:_____
Bleeding Disorder:_____ Allergies:_____
Early Heart Disease(Heart Attack less than age 50):_____
Asthma:_____

Medications:

Patientôs Current Medications:_____
_____