Medical History Form

Name ____ Date of Birth ___/___/______

Chief Complaint (current symptoms)
1. ____
2. ____
3. ____

Immunizations and Wellness: Please list month and year of last

Vaccines: Tetanus ___/____ Flu ___/____ Pneumonia ___/____ Shingles ___/____

Diabetics: Dilated Eye Exam ____/____ Foot Exam ____/____

Over 50: Colonoscopy ___/____ Bone Density Test ___/____

Female: Mammogram __/____ Pap Smear __/____ Abnormal? ☐ Yes ☐ No

Contraception Type
- ☐ Vasectomy
- ☐ IUD Year ____
- ☐ Pill
- ☐ Tubal
- ☐ Condoms
- ☐ Depo
- ☐ Other ____________

Last Menstrual Period ___/___/______

\# Pregnancies _______
\# Miscarriages ______
\# Abortions ________
\# Deliveries ________

Hysterectomy?
☐ Yes
☐ No
Reason? ______________

Male: PSA ___/____

Past Medical History: Please check all that apply

	Yes		Yes		Yes
Allergies	☐	Diabetes	☐	Seizure Disorder	☐
Anemia	☐	Heart Arrhythmia/Palpitations	☐	Sexually Transmitted Infection	☐
Anxiety Disorder	☐	Heart Attack or Bypass Surgery	☐	Stomach Ulcer	☐
Arthritis	☐	Heart Disease	☐	Stroke	☐
Asthma	☐	High Blood Pressure	☐	Thyroid disorder	☐
Birth Defects	☐	High Cholesterol	☐	Other: __________________	☐
Blood Clots	☐	Kidney Disease	☐	________________________	
Blood Transfusion	☐	Liver Disease	☐	________________________	
Bone Fracture	☐	Osteoporosis	☐	________________________	
Cancer: Type	☐	Reflux	☐	________________________	
Depression	☐	Respiratory Disease (e.g. COPD)	☐	________________________	

Surgical History: Please list any surgeries you have had and the month and year

1. ________________________ Date ___/____
2. ________________________ Date ___/____
3. ________________________ Date ___/____
4. ________________________ Date ___/____
5. ________________________ Date ___/____
6. ________________________ Date ___/____

Name ____ Date of Birth ___/___/______

Family History					
	Who		Who		Who
Blood Clots	☐ Mother Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother	Diabetes	☐ Mother Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother	Prostate Cancer	☐ Mother Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother
Breast Cancer	☐ Mother Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother	Heart Disease	☐ Mother Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother	Stroke	☐ Mother Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother
Colon Cancer	☐ Mother Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother	Osteoporosis or Hip Fracture	☐ Mother Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother	Other	☐ Mother Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother
Depression	☐ Mother Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother	Ovarian Cancer	☐ Mother Grandparent ☐ Father ☐ Maternal ☐ Sister ☐ Paternal ☐ Brother	☐ Other ______________________	

Father	Age (if living) ________	Age at death (if deceased) ________
Mother	Age (if living) ________	Age at death (if deceased) ________
Sibling	Age (if living) ________	Age at death (if deceased) ________
Sibling	Age (if living) ________	Age at death (if deceased) ________
Sibling	Age (if living) ________	Age at death (if deceased) ________

Social History					
Tobacco Use	☐ Never	Current	Packs per day _____	Year began ____	Type ☐ Cigarettes ☐ Chew ☐ Pipe ☐ Cigars ☐ E-Cigarettes
		Former	Packs per day _____	Year began ____	
Alcohol Use	☐ Never	Current	Drinks per day ____ per month ____ per year ____ Year began ______________		Type ☐ Beer ☐ Wine ☐ Liquor ☐ Other __________
		Former	Drinks per day ____ per month ____ per year ____ Year began ________________		Type ☐ Beer ☐ Wine ☐ Liquor ☐ Other __________
Caffeine	☐ Never	☐ Yes	Amount per day _____________		Type __________________
Exercise	☐ Never	☐ Yes	Sessions per week ____________		Type __________________

New PT Paperwork

PRINT: FO/Color/D05