Confidential Medical History

Date ____/_____/_____

Name_____ Birthdate____/_____/_____ Age _____

Allergies to

Medications/food/environment	Reaction	Severity	Reaction	Onset
_____		Very Mild/Mild/Moderate/Severe	_____	Adulthood/Childhood
_____		Very Mild/Mild/Moderate/Severe	_____	Adulthood/Childhood
_____		Very Mild/Mild/Moderate/Severe	_____	Adulthood/Childhood
_____		Very Mild/Mild/Moderate/Severe	_____	Adulthood/Childhood

Current medications

Name of prescription, over the counter and herbal Reason Used	Prescribing Doctor	Dose	Instructions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical Condition Past medical (include injuries and conditions requiring medication i.e.- High blood pressure, seizures etc.)

Condition	Date	Treatment
_____	____/_____/_____	_____
_____	____/_____/_____	_____
_____	____/_____/_____	_____
_____	____/_____/_____	_____
_____	____/_____/_____	_____

Surgical History:

Surgery	Date	Reason
_____	____/_____/_____	_____
_____	____/_____/_____	_____
_____	____/_____/_____	_____
_____	____/_____/_____	_____
_____	____/_____/_____	_____

Date ____/_____/_____

Name_____ Birthdate____/_____/_____ Age _____

Family History : Please complete if any of your close relatives have had any of the following:

Disease	Circle	Family Member	Family Member 1st Name	Age of onset	Age of Death	Cause of Death
Cancer of Breast	Y N	_____	_____	_____	_____	Y N
Cancer of Ovary	Y N	_____	_____	_____	_____	Y N
Cancer of Uterus	Y N	_____	_____	_____	_____	Y N
Cancer of Cervix	Y N	_____	_____	_____	_____	Y N
Cancer of Colon	Y N	_____	_____	_____	_____	Y N
Diabetes	Y N	_____	_____	_____	_____	Y N
Tuberculosis (TB)	Y N	_____	_____	_____	_____	Y N
Heart Disease	Y N	_____	_____	_____	_____	Y N
High Blood Pressure	Y N	_____	_____	_____	_____	Y N
Other	Y N	_____	_____	_____	_____	Y N

Date ____/_____/_____

Name_____ Birthdate____/_____/_____ Age _____

Social History

Do you smoke? Y N If yes, type of tobacco? _____ Number of years? _____

Packs per day? _____

Do you drink alcohol? Y N If yes, type of alcohol_____ How often? _____

Amount? _____ Last drink? _____/_____/_____

Do you consume caffeine? Y N If yes, what kind? _____ Amount? _____

Do you use recreational drugs? Y N If yes, what kind? _____

Do you exercise (frequency)? ____ Daily ____ Occasional ____ 2-3 times a week ____ 4+/week ____ Never

How many sexual partners have you had? _____ Less than 5 _____More than 5

Have you been exposed to sexual or physical violence or abuse? Y N

Are there animals in the home? Y N If yes, what kind? _____

Is the patient the individual who cleans up after the animals? Y N

If medically necessary, would you agree to a transfusion? Y N

Review of Systems

If you are experiencing any of the symptoms listed, PLEASE **CIRCLE** THE ONES THAT APPLY, or write **NONE.**

Constitutional (Health in General): Fatigue, Fever, Night sweats

Ears, Nose, Mouth and Throat: Eye discharge, Vision loss, Ear drainage, Hearing loss, Nasal drainage

Respiratory: Cough, Wheezing, Difficulty breathing or Shortness of breath

Cardiovascular: Chest pain, Irregular heartbeat, Palpitations

Gastrointestinal: Abdominal Pain, Constipation, Diarrhea, Vomiting

Dermatologic: Skin itching, Rash

Muscoloskeletal: Bone weakness, Joint weakness

Hematology: Easy bleeding, Easy brusing

Immunology: Environmental allergies, Food Allergies