



General Medical History Worksheet

Check boxes and fill in information as appropriate-use the reverse side if necessary

Name: _____ Date of Birth: _____ Date: _____

Doctor(s) to who reports should be sent: _____

Prior Hospitalizations and Surgical History

No Past Medical History

Type of Surgery/Reason for Hospitalization

Date

Physician

1. _____
2. _____
3. _____
4. _____
5. _____

Current Medications (include herbal supplements)

Currently Taking No Medication

Name of Medication

Dose/Strength

Schedule Taken

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Allergies to Medication or Materials

None Known

Allergen

Reaction

- | | |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |

Social Background

Marital Status: Married Domestic Partnership Single Divorced Widowed

Number of children: _____

Do you smoke? No Yes – If so, how many packs per day? _____ How many years? _____

Do you drink alcohol? No Occasionally Daily

Do you live with someone who can take care of you at home? No Yes

If so, who? _____

(Please complete form on reverse side)

Medical History, Review of Systems, and Family History

Have you or your *immediate* family members have had any of the following conditions?

Please check the box if "yes".

Self	Family		Self	Family	
<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis/Degenerative Joint Disease	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches/Frequent Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory Arthritis (Rheumatoid, Lupus)	<input type="checkbox"/>	<input type="checkbox"/>	Depression/Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Prior Fractures(explain): _____	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorders/Sleep Apnea
<input type="checkbox"/>	<input type="checkbox"/>	Problems with Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia/Myofascial Pain
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations/Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur/Heart Valve Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Troubles
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems/Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough/Pneumonia/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis ("Yellow Jaundice")/Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis
<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease/Emphysema/Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Coughing Up Blood
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes/High Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>	Black or Bloody Stools
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infections/Urinary Troubles	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss (Unexplained; not diet-related)
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease/Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained Fever or Shaking Chills
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Serious or Recurrent Infections (Describe): _____
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	HIV/Syphilis/Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Circulation Problems/Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer - If "yes", what type: _____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia/Bleeding/Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Other Medical Problems (Describe): _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clot/Deep Vein Thrombosis			
<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease. Give Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	

X _____
Signature of Patient, Parent, or Guardian

Date

X _____
Reviewed by MD