MEDICAL HISTORY FORM

GENERAL

NAME	Date of Birth	Today's Date
Mailing Address	Social Security #	Current age
City, State Zip	Daytime phone #	❑Work ❑Home ❑ Mobile ❑Other
Email address	Alternate phone #	❑Work ❑Home ❑ Mobile ❑Other

HEALTH HISTORY

CURRENT (ACTIVE) or RECENT Medical Conditions / Diagnoses: List **all** medical condition(s), undiagnosed symptom(s), or diagnosis(es) for which **in the past 12 months** you are currently seeing, or have seen, a physician or any other health professional, or for which you have been taking medication or receiving some form of treatment.

If NONE, check here: ❑ If None: Have you seen a physician for any reason other than a general check-up exam in the past 12 months? ❑ No ❑ Yes

#	Condition, Symptom(s) or Diagnosis	Date of Onset or Diagnosis	Treatment (list medications, surgery, self-treatment) If no treatment, write "None"	Physician(s)	Status*
A					
B					
C					
D					

If you need to continue this or any other section on a separate page, check here: ❑

*A = Active, being treated, N = Active, no current treatment I = Inactive

CURRENT MEDICATIONS (Prescription and non-prescription, including supplements, vitamins, contraceptives): If NONE, check here: ❑

#	Medication Name	Dosage	Frequency (# doses/day)	Prescribed / Taken for which Condition, symptom or diagnosis
E				
F				
G				
H				

Major PAST MEDICAL ILLNESSES, SURGERIES, HOSPITALIZATIONS, AND MAJOR INJURIES (including mental health, cosmetic, auto or other accidents):

If NONE, check here: ❑ If None: Have you ever been hospitalized overnight for any reason? ❑ No ❑ Yes

#	Condition, Problem or Diagnosis	Date(s) MM/YY	Treatment, Complications (if any)	Outcome / Status+
J				
K				
L				
M				

+R = Resolved on its own C = Cured with treatment D = No definitive diagnosis ever made N = Condition improved but still under doctor's care/observation O = Other

N **Allergies to medications, foods, or environmental agents** (name, reaction):
If NONE, check here: ❑

FAMILY HEALTH HISTORY

Indicate with the following symbols which, if any, immediate family members has any of the following types of diseases: M = Mother F = Father B = Brother S= Sister

❑ Check here if **adopted** and/or family history is unknown (leave table blank)

	Disease / Condition		If Yes: M F B S		Disease / Condition		If Yes: M F B S
O	Allergies (allergic rhinitis)	❑ No ❑ Yes		R	Mental illness	❑ No ❑ Yes	
P	Asthma	❑ No ❑ Yes		S	Coronary artery disease	❑ No ❑ Yes	
Q	Cancer (list type)	❑ No ❑ Yes		T	Other:	❑ No ❑ Yes	

	Physician Notes (Do NOT write in this area)		

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SOCIAL HISTORY

W	Highest level, grade or degree **completed**	❑ ___ Grade ❑ High school ❑ Technical Trade ❑ College ❑ AA ❑ Masters ❑ Doctorate
U	Marital / living status, current	❑ Single ❑ Never married ❑ Married _____ years ❑ Divorced, single ❑ Divorced and remarried _____ years ❑ Separated ❑ Widow(er), single ❑ Currently living with a partner ❑ Other:
V	Do you have children?	❑ No ❑ Yes If Yes: How many? Ages: How many live at home with you (full-time) ?

X	List all regular hobbies	1.	2.	3.	4.
Y	Does this hobby involve any chemical, biological, or physical hazard(s)?	❑ No ❑ Yes If Yes, List:	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes
Z	Military service	❑ No ❑ Yes If Yes: List branch, dates of service, rank, and reason for leaving/discharge:			

EMPLOYMENT / WORK HISTORY

Starting with your most recent job, list in **REVERSE order** (starting with most recent first) each job or employer you have had in the past 10 years. Include military and part-time jobs. Indicate dates of any periods of unemployment of more than 30 days. If any job lasted LESS than one year, include the MONTH in which you were hired and left.

#	From (Year)	To (Year)	Employer	City, State or Country	Job Title / Duties	Hazardous Exposures (chemicals, noise, dust, etc.)(If NONE write "None")	Injury(ies) or workers comp. claim(s)?*
1							❑ No ❑ Yes
2							❑ No ❑ Yes
3							❑ No ❑ Yes
4							❑ No ❑ Yes
5							❑ No ❑ Yes

*If Yes, and the injury/disease is not listed under Past Medical Illnesses above, please describe:

ENVIRONMENTAL HISTORY

Starting with your present home, list in REVERSE order each home you have lived in over the past 10 years:

#	From (Year)	To (Year)	City, State or Country	Type (house, apartment, etc.)	Age (years)	Pets? (If Yes, list type, #, In/Out**)	Indoor environmental problems (lead, mold, pesticides, etc.)?	Outdoor environmental problems (pollution)?
6		Present				❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes
7						❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes
8						❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes

**In = Indoor only Out = Outdoor only I/O=Lives both indoors AND outdoors

LIFESTYLE

9	How do you rate your overall current health? (Check one)	❑ Excellent ❑ Good ❑ Fair ❑ Poor	10	On average, how many **hours** of sleep do you get each night?	Hours
11	Are you satisfied with your current diet?	❑ No ❑ Yes	12	Are you satisfied with your current body weight?	❑ No ❑ Yes
13	Do you exercise regularly (other than work-related physical activity)?	❑ No ❑ Yes	14	List types of exercise and frequency:	

15	Do you regularly drink caffeinated beverage(s)? ❑ No ❑ Yes If Yes, what kind(s) (Check all that apply):	❑ Coffee	❑ Tea	❑ Other:
16	**Daily Quantity** (average or typical # of cups or drinks in one day):			
17	Do you consume alcoholic beverages? ❑ No ❑ Yes If Yes, what kind(s) (Check all that apply):	❑ Beer	❑ Wine	❑ Liquor:
18	**Weekly Quantity** (average or typical # of glasses, cans/bottles, or drinks in one week):			
19	**Frequency** 1 = Daily or most days 2 = 2-4 days per week 3 = Once a week or less 4 = Weekends only 5 = Socially or holidays only			

		Do you NOW or have you in the PAST smoked or used… (One "X" per row)			If Currently or Past, Quit:				If Past, Quit:	If Currently:
		Never ⊙	Past, Quit ⊙⊙	Currently ⊙⊙⊙	Age you started	Average # per day	Maximum # per day	Total # years	Age You Quit Permanently	Do You Want to Quit?
20	Cigarettes?									❑ No ❑ Yes
21	Cigars or pipe?									❑ No ❑ Yes
22	Chewing tobacco?									❑ No ❑ Yes

⊙ Less than 30 days total or tried but never used regularly ⊙⊙ More than 30 days ago and have not smoked or used at all since then ⊙⊙⊙ Any time in the past 30 days

	Physician Notes (Do NOT write in this area)		

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