MEDICAL HISTORY FORM

Last Name: ____________________________ **First Name** ________________________ **DOB:** _______________

Primary Doctor: _______________________________ **Referring Doctor:** ________________________________

ALLERGY TO MEDICATIONS: ___ NONE ___ Penicillin ___ Sulfa drugs
Other: ____

PAST MEDICAL HISTORY
(Illnesses you currently have or previously treated for) Check all that apply

__ Diabetes
__ High blood pressure
__ Sleep apnea
__ Kidney disease
__ Hearing loss
__ Cancer, type: _________
__ Heart disease
__ Asthma
__ High cholesterol
__ Depression
__ Seizures
__ Other conditions: ____________________________
__ COPD
__ Stroke
__ Thyroid disease
__ Liver disease
__ Bleeding disorder

CURRENT MEDICATIONS (For additional space, use back of paper)	**DOSE**	**FREQUENCY**

WEIGHT: ___________________ **HEIGHT:** ____________________

FAMILY MEDICAL HISTORY:

Mother: __ alive __deceased Medical conditions: ____________________
Father: __ alive __deceased Medical conditions: ____________________

ADVANCED CARE PLAN:
Do you have an advanced directive? Y or N
Do you have a medical power of attorney? Y or N

TOBACCO USE: ___Never ___Former Smoker ___Current smoker ___Vape
How many years have you smoked? _______ At what age did you start smoking? _____
How many packs of tobacco do you smoke per week?

ALCOHOL USE:
What is your level of alcohol consumption? (CIRLCE ONE) NONE OCCASIONAL MODERATE HEAVY
How many days in the past year have you consumed 4 or more drinks? _____
Have you ever been counseled for unhealthy alcohol use? _____

SURGICAL HISTORY (For additional space, use back of paper)	**YEAR**

Patient signature: _______________________________ **Date:** _________________