

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

**MEDICAL HISTORY FORM**

**Family History: (circle if positive)**

DIABETES	ASTHMA OR ALLERGIES	MENTAL RETARDATION
HYPERTENSION, STROKE	ULCERS	ALCOHOL PROBLEMS
HEART DISEASE, MI	ANEMIA	DRUG PROBLEMS
TUBERCULOSIS	BLOOD DISORDER	BIRTH DEFECTS
ARTHRITIS	EPILEPSY	THYROID PROBLEMS
CANCER	GLAUCOMA	
KIDNEY DISEASE	NERVOUS BREAKDOWN	

**Condition of:**            Deceased            Alive & Well            Other

MOTHER  
FATHER  
BROTHERS  
SISTERS

**Patient's (your) Past Medical History (list dates)**

Usual childhood diseases    Rheumatic fever  
Heart disease, stroke  
Hypertension, stroke  
Kidney disease (infections or stones)  
Liver disease  
Ulcer or bowel problems  
Pneumonia, Bronchitis, Tuberculosis, Asthma  
Diabetes  
Venereal Disease (type and treatment)  
Arthritis  
Thyroid disease  
Cancer (type and therapy)  
Epilepsy  
Nervous breakdown  
Mental problems  
Convulsion, seizure  
Mother took Stilbesterol  
Asthma or allergies

**HOSPITALIZATIONS (include medical and surgical: date & reason)**

**INJURIES: (broken bones, sprains, accidents)**

**ALLERGIES:**

**MEDICATIONS:**

Cigarette Smoker: Yes \_\_\_\_\_ Never \_\_\_\_\_ No. of packs/day \_\_\_\_\_ How long \_\_\_\_\_ If quit/when \_\_\_\_\_  
Alcohol intake: type \_\_\_\_\_ amount \_\_\_\_\_ how often \_\_\_\_\_  
Drug abuse: type \_\_\_\_\_ amount \_\_\_\_\_ how often \_\_\_\_\_