PATIENT MEDICAL HISTORY FORM

PATIENT NAME				
GENDER: **Male Female**	**BIRTHDATE**	**AGE**	**HEIGHT**	**WEIGHT**

1. ALLERGIES: *(LIST ALL ALLERGIES TO MEDICATIONS, FOOD, SHELL FISH, LATEX, ETC.)*

1	*6*	*11*
2	*7*	*12*
3	*8*	*13*
4	*9*	*14*
5	*10*	*15*

2. MEDICATIONS:*(LIST ALL PRESCRIPTION, OVER-THE-COUNTER MEDICATIONS, VITAMINS, SUPPLEMENTS DOSE & DIRECTIONS)*

MEDICATION	*DOSE*	*DIRECTIONS/REASON*
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

3. IMMUNIZATIONS & VACCINATIONS:

DESCRIPTION	*STATUS*	*MONTH & YEAR RECEIVED*
IMMUNIZATIONS	*CURRENT* *PAST DUE*	
FLU VACCINATION	*CURRENT* *PAST DUE*	
PNEUMONIA VACCINATION	*CURRENT* *PAST DUE*	

4. FAMILY MEDICAL HISTORY:

PROBLEM LIST	FATHER	MOTHER	BROTHER	SISTER	CHILDREN	PATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	MATERNAL GRANDMOTHER
ADDICTIONS	☐	☐	☐	☐	☐	☐	☐	☐	☐
ALLERGIES OR HAYFEVER	☐	☐	☐	☐	☐	☐	☐	☐	☐
ARTHRITIS	☐	☐	☐	☐	☐	☐	☐	☐	☐
ASTHMA	☐	☐	☐	☐	☐	☐	☐	☐	☐
BIRTH DEFECTS	☐	☐	☐	☐	☐	☐	☐	☐	☐
BLEEDING DISORDER	☐	☐	☐	☐	☐	☐	☐	☐	☐
BRONCHITIS	☐	☐	☐	☐	☐	☐	☐	☐	☐
CANCER (TYPE)	☐	☐	☐	☐	☐	☐	☐	☐	☐
CYSTIC FIBROSIS	☐	☐	☐	☐	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐	☐	☐	☐	☐
ECZEMA	☐	☐	☐	☐	☐	☐	☐	☐	☐
EMPHYSEMA	☐	☐	☐	☐	☐	☐	☐	☐	☐
EPILEPSY	☐	☐	☐	☐	☐	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐	☐	☐	☐
IMMUNE DISORDER	☐	☐	☐	☐	☐	☐	☐	☐	☐
KIDNEY DISEASE	☐	☐	☐	☐	☐	☐	☐	☐	☐
MIGRAINE HEADACHES	☐	☐	☐	☐	☐	☐	☐	☐	☐
PSYCHIATRIC DISORDER	☐	☐	☐	☐	☐	☐	☐	☐	☐
SINUS	☐	☐	☐	☐	☐	☐	☐	☐	☐
STOMACH/BOWEL	☐	☐	☐	☐	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐	☐	☐	☐	☐
THYROID	☐	☐	☐	☐	☐	☐	☐	☐	☐

PATIENT NAME	DATE OF BIRTH

5. SOCIAL & ENVIRONMENTAL (CIRCLE & ANSWER ALL THAT APPLY)

PRODUCT	CIRCLE RESPONSE	QUANTITY	DURATION &/OR YEAR QUIT
ALCOHOLIC BEVERAGES	YES NO		
CAFFIENE	YES NO		
TOBACCO	YES NO		
RECREATIONAL DRUGS	YES NO		

PRIMARY RESIDENCE	CITY CITY-SUBURB RURAL-SUBURB FARM HOUSE CONDO/TOWNHOUSE APARTMENT MOBILE HOME FINISHED BASEMENT UNFINISHED BASEMENT EARTHFLOOR IN BASEMENT NO BASEMENT LIVED IN PACIFIC NORTHWEST LIVED IN OTHER COUNTRIES LIVED IN OTHER STATES		
	AGE OF HOME: _____	#YEARS LIVING AT HOME: _____	# OF PERSONS IN HOME: _____
HEAT/AIRCONDITIONING	CENTRAL RADIATOR ELECTRIC GAS IN-WINDOW CEILING FANS		
FLOORING	HARWOOD (AGE OF HARDWOOD: _____) CARPET (AGE OF CARPET: _____)		
BASEMENT/CRAWL SPC	DRY DAMP MUSTY		
BEDROOM INFO	MATTRESS/BOXSPRING WATERBED BUNK BED FUTON BED (AGE OF BED: _____)		
PILLOW INFO	FEATHER PILLOW NON-FEATHER PILLOW OTHER: (AGE OF PILLOW: _____)		
PETS	DOGS CATS OTHER: INDOOR OUTDOOR ALLOWED IN BEDROOM		
SMOKERS	NONE INDOORS: OUTDOORS		
OTHER ENVIRONMENTALS			
CHIDREN UNDER 15 YRS:	BIRTH WEIGHT: COMPLICATIONS FOLLOW DELIVERY GROWTH/DEVELOPMENT NORMAL OR ABNORMAL		

6. HOSPITALIZATIONS & SURGERIES: *(LIST HOSPTIALIZATION / SURGERY AND GIVE APPROXIMATE MONTH & YEAR OF HOSPITALIZATION/SURGERY)*

1
2
3
4
5
6
7
8
9
10

PATIENT NAME	DATE OF BIRTH

7. **MEDICAL CONDITIONS:** *(CIRCLE ALL MEDICAL CONDITIONS THAT APPLY)*

AIDS/HIV ABUSE/DOMESTIC VIOLENCE ALLERGIES ANEMIA ANESTHESIA COMPLICATIONS ANXIETY DISORDER ARHRITIS ASTHMA AUTISM SPECTRUM DISORDER BEDWETTING BIRTH DEFECTS BLADDER INFECTIONS BLADDER OR KIDNEY PROBLEMS BLOOD DISORDER BLOOD TRANSFUSION BREAST PROBLEM COPD CANCER CHICKEN POX COLITIS CONGENTIAL ANOMALIES CONGESTIVE HEART FAILURE CONSTIPATION CORONARY ARTERY DISEASE CROUP DEPRESSION DEVELOPMENT/BEHAVIORAL DISORDERS DIABETES DIVERTICULITIS EAR/HEARING PROBLEMS EARTING DISORDER ECZEMA EMPHYSEMA ENDOMETRIOSIS FIBROMYALGIA GI PROBLEMS GASTROESOPHAGEAL REFLEX DISEASE GOUT HEAD INJURY/CONCUSSION HEADACHES HEART PROBLEMS/MURMUR HEPATITIS HIGH BLOOD PRESSURE HIGH CHOLESTEROL HYPERTENSION HYPERTHYROIDISM INFERTILITY KIDNEY DISEASE LIVER DISEASE LUNG DISEASE MENTAL DISORDER MENTAL ILLNESS MIGRANES MITRAL VALVE PROLAPSE MUSCLE/JOINT/BONE PROBLEMS NASAL POLYPS OBESITY OSTEOPOROSIS OVARIAN CANCER POLYPS PRE-ECLAMPSIA PROSTATE PROBLEMS PULMONARY EMBOLISM REFLUX/GERD SEZURES/EPILEPSY SKIN PROBLEMS STROKE THROMBOPHILIAS THYROID PROBLEMS TUBERCULOSIS ULCERS VARICOSITIES VISION PROBLEMS MRSA EXPOSURE

OTHER:

REVIEW OF SYSTEMS: (CIRCLE ALL THAT APPLY)

CONSTITUTIONAL	FEVER NIGHT SWEATS WEIGHT GAIN WEIGHT LOSS EXERCISE INTOLERANCE
EYES	DRY EYES: *RIGHT LEFT BOTH* EYE IRRITATION: *RIGHT LEFT BOTH* VISION CHANGES: *RIGHT LEFT BOTH*
EARS, NOSE, THROAT, MOUTH	HEARING DEFICIT: *RIGHT LEFT BOTH* EAR PAIN: *RIGHT LEFT BOTH*
CARDIOVASCULAR	CHEST PAIN ARM PAIN SHORTNESS OF BREATH PALPITATIONS HEART MURMUR LIGHT HEADED/DIZZY
RESPIRATORY	COUGHING SLEEP APNEA WHEEZING SHORTNESS OF REATH
GASTROINTESTINAL	ABDOMINAL PAIN VOMITING INCREASED APPETITE DECREASED APPETITE DIARRHEA DYSPEPSIA GERD
GENTIURINARY	PAIN WITH URINATION URINARY DRIBBLING INABILITY TO URINATE BLOOD IN URINE
MUSCULOSKELETAL	MUSCLE WEAKNESS SWELLING IN EXTREMITIES MUSCLE ACHES
INTEGUMENTARY	ABNORMAL MOLE JAUNDICE RASH LACERATION
NEUROLOGICAL	LOSS OF CONSCIOUSNESS WEAKNESS NUMBNESS SEIZURES DIZZINESS HEADACHES
PSYCHIATRIC	DEPRESSION SLEEP DISTURBANCES STRESS IN RELATIONSHIP SUBSTANCE ABUSE
ENDOCRINE	FATIGUE
HEMATOLOGIC	SWOLLEN GLANDS BRUISING
ALLERGY	ITCHING HIVES RUNNY NOSE SINUS PRESSURE FREQUENT SNEEZING