



General Medical History Worksheet

Check boxes and fill in information as appropriate

Name: _____ Date of Birth: _____ Date: _____

Who are your primary doctor(s) to whom reports should be sent? _____

Past Medical History

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Diabetes/High Blood Sugar | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack/Heart Disease | <input type="checkbox"/> Lung Disease/Emphysema (explain): _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Gout | <input type="checkbox"/> Prior Fractures/Broken Bones (explain): _____ |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Inflammatory Arthritis (Rheumatoid, Lupus, Psoriatic, Spondylitis) |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stroke/T.I.A. | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Bowel and GI Problems (explain): _____ |
| <input type="checkbox"/> Urinary Tract Infections | <input type="checkbox"/> Anemia/Hemophilia | <input type="checkbox"/> Blood Clot/Deep Vein Thrombosis | <input type="checkbox"/> Serious Infections (explain): _____ |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Breast Disease | <input type="checkbox"/> Poor Circulation or Vascular Disease | <input type="checkbox"/> Sexually Transmitted Disease (explain): _____ |
| <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Eating Disorder/Poor Nutrition | <input type="checkbox"/> Skin Disease (explain): _____ |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> Gastric Ulcers | <input type="checkbox"/> Hepatitis ("Jaundice")/Liver Disease |

Cancer History (type and current status): _____

Other Medical Problems: _____

Prior Hospitalizations and Surgical History

No Past Medical History

Type of Surgery/Reason for Hospitalization	Date	Surgeon/Physician
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Current Medications (include herbal supplements and attach sheet if necessary)

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. _____	_____

Social Background

Marital Status: Married Domestic Partnership Single Divorced Widowed

Age(s) of children: _____ Can someone care for you at home? No Yes who? _____

Do you drink caffeinated beverages? No Yes If so, how much per day? _____

Do you have a history of illicit drug use? No Yes If so, explain: _____

Do you use tobacco? No Yes If so, how much/ packs per day? _____ How many years? _____

Previously used tobacco? No Yes If so, did you quit 1 year ago > 5 years ago > 10 years ago

Do you drink alcohol? No Occasionally Daily How much? _____

Family Medical History

Relation	Age	State of Health	Age of Death	Medical Problems or Cause of Death
Mother				
Father				
Sibling <input type="checkbox"/> Bro <input type="checkbox"/> Sis				
Sibling <input type="checkbox"/> Bro <input type="checkbox"/> Sis				
Sibling <input type="checkbox"/> Bro <input type="checkbox"/> Sis				
Grandfather (maternal)				
Grandmother (maternal)				
Grandfather (paternal)				
Grandmother (paternal)				

Review of Systems: Are you currently having or have you had problems with:

Condition	Check a Box	Please Describe all "Yes" Responses
Fever or Shaking Chills	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Weight Loss (not Diet related)	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Chest Pain	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Lung or Breathing Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Irregular Heart Beat	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Problems Urinating	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Loss of Strength or Numb/Tingling	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Bowel or Stool Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Vision Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Skin Issues	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Pregnancy or Menstrual Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Lumps or Masses (incl. Breast)	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Fainting/Seizures/Blackout	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Bleeding or Blood Clots	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Psychiatric Issues	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Problems with Anesthesia	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Ears, Nose or Throat	<input type="checkbox"/> No <input type="checkbox"/> Yes	

X _____
Signature of Patient, Parent, or Guardian

Date

X _____
Reviewed by MD