

Medical History

Patient Name: \_\_\_\_\_ Sex: M F Date: \_\_\_\_\_

Age: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Primary Language Spoken: \_\_\_\_\_

PCP: \_\_\_\_\_ Phone#: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Phone#: \_\_\_\_\_

Chief Complaint /Reason for Visit: \_\_\_\_\_

Past Medical History /Health Conditions:

\_\_\_\_\_  
\_\_\_\_\_

Pregnant?  Yes  No Nursing?  Yes  No

Past Surgical History?  Yes  No If yes, please list procedure and date:

\_\_\_\_\_  
\_\_\_\_\_

Family History of Medical Problems?  Yes  No If yes, please list and indicate family member:

\_\_\_\_\_  
\_\_\_\_\_

Are you currently using any tobacco products?  Yes  No If yes, quantity: \_\_\_\_\_

If you quit, how much did you smoke? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you consume Alcohol?  Yes  No If yes, quantity: \_\_\_\_\_ Frequency: \_\_\_\_\_

Do you currently or have you had a problem with substance abuse in the past ?  Yes  No

Please list all Allergies, including Medication, Environmental, Food, & Latex: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

No Known Allergies

List all medications you are currently taking, including over the counter medications and vitamins:

\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_

*(If patient is a minor, then person completing the Medical history and relationship)*