Medical History Form

Please list current health information as completely as possible. Bring medication bottles or an updated medication list when available.

CURRENT MEDICATIONS

Medication name, dose, frequency, and prescribing clinician

ALLERGIES

Medication, food, latex, or other allergies and reaction type

PHARMACIES

Preferred Pharmacy Name

Phone

Address

Medical History Form

MEDICAL CONDITIONS

- [ ] High blood pressure
- [ ] High cholesterol
- [ ] Diabetes / prediabetes
- [ ] Heart disease
- [ ] Asthma / COPD
- [ ] Thyroid disease
- [ ] Kidney disease
- [ ] Liver disease
- [ ] Cancer history
- [ ] Stroke / TIA
- [ ] Depression / anxiety
- [ ] Other

Other chronic conditions or important diagnoses

SURGICAL / HOSPITAL HISTORY

Past surgeries, hospitalizations, or major procedures with approximate dates

FAMILY MEDICAL HISTORY

Major conditions in parents, siblings, children, or close relatives

Medical History Form

LIFESTYLE AND PREVENTIVE HEALTH

- [ ] Never smoker
- [ ] Former smoker
- [ ] Current smoker
- [ ] Alcohol use
- [ ] Exercise routinely
- [ ] Sleep concerns
- [ ] Special diet
- [ ] Work stress / caregiving stress

Nutrition, activity, sleep, stress, or substance-use notes you want the doctor to know

PREVENTIVE CARE

Recent vaccines, screenings, mammogram, colonoscopy, bone density test, or labs

SIGNATURE

Patient / Guardian Signature

Date