MEDICAL HISTORY FORM

Name:	**Date of Birth:**	**Age:**	**Sex:**	**Ethnicity:**

Current Address:	**Home Phone Number:** ☐ N/A	**Cell Phone Number:** ☐ N/A

Emergency Contact Name: ☐ N/A	**Emergency Contact Address:** ☐ N/A	**Emergency Contact Cell Phone Number:** ☐ N/A

Email Address:	**Preferred Method of Contact:**

Do you Have a Primary Care Physician? ☐ Yes ☐ No	**Physician Name:** ☐ N/A	**City:** ☐ N/A	**Phone:** ☐ N/A
Do you see any Specialists? ☐ Yes ☐ No	**Physician Name:** ☐ N/A	**City:** ☐ N/A	**Phone:** ☐ N/A

PERSONAL INFORMATION

Marital Status:	**Occupation:**	**I am currently:** ☐ Working ☐ Retired ☐Unemployed
Alcohol Consumption: ☐ Never ☐ Social ☐ Daily ☐ Binge	**Amount Consumed per Week?**	**Night Shift Worker?** ☐Yes ☐No
Current Caffeine Consumption: ☐ Coffee ☐ Tea ☐ Soda ☐ None	**How Many Cups Daily:** Coffee: _____ Tea: _____ Soda: _____ ☐ None	**Type of Alcohol Consumed:** ☐ Beer ☐ Wine ☐ Liquor

I Currently Use:	**Do you Currently Use any Recreational Drugs?**
☐ Glasses For: _____ Since: _____ ☐ Contact Lenses For: _____ Since: _____ ☐ Hearing Aids For: _____ Since: _____	☐ No ☐ Yes Type: _____

Smoking Status:	**If QUIT:**
☐ Current ☐ Former ☐ Never	Date of Last Known Usage: _____ # Years Smoked: _____ Average Packs per Day: _____

Completing Individual's Initials & Date: _____

FAMILY HISTORY

Mother: ☐ Alive ☐ Deceased ☐ Unknown	**Age:**	**Cause of Death:** ☐ N/A
Father: ☐ Alive ☐ Deceased ☐ Unknown	**Age:**	**Cause of Death:** ☐ N/A

Did/Does any of your immediate family members have any of the following conditions?

Asthma	☐ Yes ☐ No	Relationship:
High Blood Pressure	☐ Yes ☐ No	Relationship:
High Cholesterol	☐ Yes ☐ No	Relationship:
Diabetes	☐ Yes ☐ No	Relationship:
Heart Attack or Heart Failure	☐ Yes ☐ No	Relationship:
Stroke	☐ Yes ☐ No	Relationship:
Other (Please Specify):	☐ Yes ☐ No	Relationship:

WOMEN ☐ N/A, MALE

Are You:

☐Pregnant (Weeks: _____) ☐ Planning on becoming pregnant ☐ Breastfeeding

☐ Using Contraceptives ☐ Post-Menopausal ☐ Surgically Sterile ☐ Have Irregular Menses

If Using Contraceptives:

☐ Oral contraceptives
☐ IUD ☐ Contraceptive implant
☐ Contraceptive injection ☐ Condom and spermicide
☐ Diaphragm and spermicide ☐ Total Abstinence
☐ Other: _____

Name: _____ Since: _____

Date of Last Menses: _____

If Post-Menopausal: ☐ N/A

Date of Last Menses: _____

If Surgically Sterile: ☐ N/A

☐ Hysterectomy Date:_____
☐ Bilateral Tubal Ligation Date:_____
☐ Bilateral Tubal Occlusion Date:_____
☐ Bilateral Salpingo-oophorectomy
☐ Other: _____

Any history of sexually transmitted disease of infections? ☐ Yes ☐ No
If yes, please specify:
STD/STI: _____ Start Date: _____ Stop Date/Ongoing: _____

MEN ☐ N/A, FEMALE

Sexually Active: ☐ Yes ☐ No	**If YES: Do you have a female partner of childbearing potential?** ☐ Yes ☐ No	**Have you had any of the following:** ☐ Vasectomy-Year: _____ ☐ Other: _____

Any history of sexually transmitted disease of infections? ☐ Yes ☐ No
If yes, please specify:
STD/STI: _____ Start Date: _____ Stop Date/Ongoing: _____

Completing Individual's Initials & Date: _____

PERSONAL MEDICAL INFORMATION

CARDIOVASCULAR			Start Date	Stop Date/Ongoing
High Blood Pressure	☐Yes	☐No		
High Cholesterol	☐Yes	☐No		
Heart Attack	☐Yes	☐No		
Heart Disease	☐Yes	☐No		
Other:_____	☐Yes	☐No		
STOMACH/DIGESTIVE			**Start Date**	**Stop Date/Ongoing**
Stomach Ulcer	☐Yes	☐No		
GERD	☐Yes	☐No		
Liver Disease	☐Yes	☐No		
Hepatitis ☐ A ☐ B ☐ C	☐Yes	☐No		
Hepatitis B Vaccinated	☐Yes	☐No		
Crohn's Disease	☐Yes	☐No		
Eosinophilic Esophagitis (EOE)	☐Yes	☐No		
Other:_____	☐Yes	☐No		
MUSCULOSKELETAL			**Start Date**	**Stop Date/Ongoing**
Bone Fractures:_____ *(location)*	☐Yes	☐No		
Bone Fractures:_____ *(location)*	☐Yes	☐No		
Bone Fractures:_____ *(location)*	☐Yes	☐No		
Arthritis: _____ *(location)*	☐Yes	☐No		
Scoliosis	☐Yes	☐No		
Chronic Back Aches	☐Yes	☐No		
Other:_____	☐Yes	☐No		
RESPIRATORY/LUNG			**Start Date**	**Stop Date/Ongoing**
Asthma	☐Yes	☐No		
COPD	☐Yes	☐No		
Tuberculosis	☐Yes	☐No		
Other:_____	☐Yes	☐No		
DERMATOLOGICAL/SKIN			**Start Date**	**Stop Date/Ongoing**
Eczema	☐Yes	☐No		
Chronic Hives/Idiopathic Urticaria	☐Yes	☐No		
Psoriasis	☐Yes	☐No		
MRSA	☐Yes	☐No		
Other:_____	☐Yes	☐No		
HEMATOLOGICAL/BLOOD			**Start Date**	**Stop Date/Ongoing**
Anemia	☐Yes	☐No		
AIDS/HIV	☐Yes	☐No		
Blood Transfusion	☐Yes	☐No		
Other:_____	☐Yes	☐No		
GENITOURINARY			**Start Date**	**Stop Date/Ongoing**
Chronic Urinary Tract Infections	☐Yes	☐No		
Kidney Disease	☐Yes	☐No		
Other:_____	☐Yes	☐No		

Completing Individual's Initials & Date: _____

PERSONAL MEDICAL INFORMATION-Continued

ENDOCRINE/METABOLIC			Start Date	Stop Date/Ongoing
Diabetes ☐Type I ☐Type II	☐Yes	☐No		
Hypothyroid Disease	☐Yes	☐No		
Hyperthyroid Disease	☐Yes	☐No		
Obesity	☐Yes	☐No		
Other:_____	☐Yes	☐No		
NERVOUS/NEUROLOGICAL/PSYCHIATRIC			**Start Date**	**Stop Date/Ongoing**
Depression	☐Yes	☐No		
Anxiety Disorder	☐Yes	☐No		
Bipolar Disorder	☐Yes	☐No		
Insomnia	☐Yes	☐No		
☐ADHD ☐ADD	☐Yes	☐No		
Frequent Headaches	☐Yes	☐No		
Frequent Migraines	☐Yes	☐No		
Seizures	☐Yes	☐No		
Stroke	☐Yes	☐No		
Alzheimer's Disease	☐Yes	☐No		
Dementia	☐Yes	☐No		
Concussion	☐Yes	☐No		
Other:_____	☐Yes	☐No		
EAR, EYE, NOSE, THROAT			**Start Date**	**Stop Date/Ongoing**
Allergic Rhinitis/Environmental Allergies	☐Yes	☐No		
Chronic Sinusitis	☐Yes	☐No		
Nasal Polyps	☐Yes	☐No		
Cataracts: R / L	☐Yes	☐No		
Glaucoma: R / L	☐Yes	☐No		
Nearsighted: R / L	☐Yes	☐No		
Farsighted: R / L	☐Yes	☐No		
OTHER			**Start Date**	**Stop Date/Ongoing**
Cancer:_____	☐Yes	☐No		
Immunotherapy/Allergy Shots Dose: Frequency:	☐Yes	☐No		
Other: _____	☐Yes	☐No		
Other: _____	☐Yes	☐No		
Other: _____	☐Yes	☐No		

Completing Individual's Initials & Date: _____

SURGERIES/HOSPITALIZATIONS/ER VISITS

Please list ALL of your previous and planned SURGERIES, HOSPITALIZATIONS, and significant ER VISITS	
Name/Event:	**Date:**

ALLERGY INFORMATION

Are you allergic to any medications?		☐Yes	☐No		
Medication				**Start Date**	**Stop Date/Ongoing**
Type:_____		☐Yes	☐No		
Type: _____		☐Yes	☐No		
Type: _____		☐Yes	☐No		
Type: _____		☐Yes	☐No		
Are you allergic to any foods?		☐Yes	☐No		
Food				**Start Date**	**Stop Date/Ongoing**
Food: _____		☐Yes	☐No		
Food: _____		☐Yes	☐No		
Food: _____		☐Yes	☐No		
Food: _____		☐Yes	☐No		
Food: _____		☐Yes	☐No		
Food: _____		☐Yes	☐No		
Are you allergic to any environmental allergen?		☐Yes	☐No		
Allergen (ex. grass, trees, mold, dust)				**Start Date**	**Stop Date/Ongoing**
Allergen: _____		☐Yes	☐No		
Allergen: _____		☐Yes	☐No		
Allergen: _____		☐Yes	☐No		
Allergen: _____		☐Yes	☐No		
Allergen: _____		☐Yes	☐No		

Completing Individual's Initials & Date: _____

Travel History

Have you traveled out of the country in the past five years? ☐**Yes** ☐**No**		
Do you have a history of any parasitic infections? ☐**Yes** ☐**No**		
Where:	**When:**	**How Long:**
Where:	**When:**	**How Long:**
Where:	**When:**	**How Long:**

CURRENT MEDICATIONS

Please list all medications (prescribed or over-the-counter), vitamins, and supplements the patient is currently taking.

NAME	DOSE	FREQUENCY	START DATE	STOP DATE
				☐ Ongoing
				☐ Ongoing
				☐ Ongoing
				☐ Ongoing
				☐ Ongoing
				☐ Ongoing
				☐ Ongoing
				☐ Ongoing
				☐ Ongoing

I confirm that to the best of my knowledge the above information is accurate.

Completing Individual's Printed Name: _____

Relationship to patient if not the patient: _____ ☐ N/A, completing individual is the patient

Completing Individual's Signature: _____ Date: _____