PATIENT MEDICAL HX FORM

Patient Name: _____
Date of Birth: _____
Account #: _____

Patient Current Medications
(List all prescription medications, over-the-counter medicines, vitamins, and supplements.)

Medication Name	*Dose*	*How Often?*

Need more space? Use the back. Have a medication list? Attach it.

Patient Medical History

Check any condition you have now or have had in the past. If you check a box, write details next to it when applicable

☐ Allergies or Skin Problems (Eczema, psoriasis, rashes, seasonal allergies) Details: _____
☐ Autoimmune Condition Details: _____
☐ Blood Disorders (Anemia, sickle cell) Details: _____
☐ Bone, Joint, or Muscle Problems (Arthritis, cerebral palsy, spine problems, osteoporosis) Details: _____
☐ Breathing Problems (Asthma, bronchitis, chronic cough, pneumonia) Details: _____
☐ Cancer (Breast, oropharyngeal, leukemia) Details: _____
☐ Dental Problems (Tooth pain, bleeding gums, jaw problems/TMJ) Details: _____
☐ Developmental or Learning Conditions (Autism, ADHD, delays) Details: _____
☐ Diabetes
☐ Digestive or Stomach Problems (Acid reflux, chronic stomach issues) Details: _____
☐ Liver Problems (Fatty liver, cirrhosis, hepatitis, hemochromatosis) Details: _____
☐ Heart or Circulation Problems (Heart disease, high blood pressure, pacemaker, valve replacement) Details: _____
☐ History of Blood Transfusions
☐ Infectious Diseases (Tuberculosis, cold sores, sexually transmitted infections) Details: _____
☐ Joint Replacement Details: _____
☐ Kidney or Urinary Problems (Frequent infections, kidney disease, bladder or prostate problems) Details: _____
☐ Mental Health Concerns (Anxiety, depression, bipolar disorder, schizophrenia) Details: _____
☐ Premature Birth
☐ Pregnancy (current or past complications)
☐ Reproductive Health Issues (Heavy bleeding, PCOS, infertility, yeast infections) Details: _____
☐ Seizures or Neurological Problems (Epilepsy, stroke, fainting, dizziness) Details: _____
☐ Substance Use (Alcohol, drugs) Details: _____
☐ Taking Bone Hardening Medication (Bisphosphonates)
☐ Thyroid Problems
☐ Tobacco or Vaping Use
☐ Vision or Hearing Problems (Glasses, hearing aids) Details: _____
☐ Weakened Immune System (HIV/AIDS, organ transplant) Details: _____
☐ Other Health Concerns Details: _____

Allergies

Food, insect, animal, or seasonal allergies	☐ Yes	☐ No	If yes, list: _____
Medication Allergies	☐ Yes	☐ No	If yes, list: _____
Latex Allergy	☐ Yes	☐ No	

Have you ever had a reaction to a vaccine? ☐ Yes ☐ No If yes, which vaccine and what happened? _____

Have you ever stayed in the hospital? ☐ Yes ☐ No Reason: _____

Have you ever had surgery? ☐ Yes ☐ No Type of surgery: _____

Have you gone to the ER in the past year? ☐ Yes ☐ No Reason for visit: _____

Family Medical History *Check all that apply and list the affected relative(s) (e.g., Parent, Sibling, Grandparent).*

☐ Anemia	☐ Seizures	☐ Cancer	☐ Alcohol or drug abuse	
☐ Stroke	☐ SIDS	☐ Tuberculosis	☐ High cholesterol	Relative(s) affected:
☐ Heart disease	☐ HIV/AIDS	☐ Migraines	☐ Other: _____	_____
☐ High blood pressure	☐ Sickle cell disease	☐ Arthritis	_____	_____
☐ Diabetes	☐ Asthma	☐ Dental problems		

Signature of Patient, Parent or Guardian: _____ **Date:** ___/___/_____
Provider Signature: _____ **Date:** ___/___/_____