

PATIENT MEDICAL HISTORY FORM

PATIENT NAME: _____

DATE: _____

DATE OF BIRTH: _____

OCCUPATION: _____

PAST MEDICAL HISTORY: Do you have or have you had any of the following: (Please circle answers.)

Diabetes	Yes	No	High or low blood pressure	Yes	No
Cancer	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Arthritis/Gout/Rheumatism	Yes	No
Convulsions	Yes	No	Blood Disease	Yes	No
Hay Fever or Asthma	Yes	No	Venereal Disease	Yes	No
Lung Disease	Yes	No			
Have you ever had a blood transfusion?			Yes	No	
Are you taking or have you ever taken steroids for any reason?			Yes	No	

CURRENT MEDICATIONS:

NAME	DOSAGE (if known)	FREQUENCY
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____

DRUG ALLERGIES (please list): _____

PAST SURGERIES AND DATES IF KNOWN:

1) _____	YEAR: _____	4) _____	YEAR: _____
2) _____	YEAR: _____	5) _____	YEAR: _____
3) _____	YEAR: _____	6) _____	YEAR: _____

Have you ever been advised to have a surgical procedure which has never been done? Yes No
If so, please state the procedure and when it was recommended: _____

SOCIAL HISTORY: (Please circle answers, when applicable)

1) Do you Smoke or use tobacco? Yes No If yes, how many years _____ Number of packs per day? _____
If you have quit, when did you quit? _____ How many packs per day did you smoke? _____

2) Do you use recreational drugs? Yes No

3) Do you drink alcohol? Yes No If yes, how many drinks per week? _____
If no longer drink alcohol, when did you quit? _____ Number of drinks per week? _____

4) Do you work in a noisy environment? Yes No

5) Are you frequently exposed to loud noises? Yes No

6) Have you ever been in the Military? Yes No

Reason for seeing the Doctor today: _____

(PLEASE COMPLETE BACK OF FORM.)