

MEDICAL HISTORY SHEET

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Patient Name: _____ Date: _____

If you have a list of medications, surgeries, allergies, etc., please give a copy to the receptionist you do not have to write them on this list.

CURRENT MEDICAL PROBLEM(S)

When Did Injury/Symptoms Begin?

PAST PERSONAL MEDICAL HISTORY

(check all that apply)

- high blood pressure _____
- diabetes _____
- heart disease _____
- ulcers _____
- lung disease _____
- asthma _____
- history of blood clot _____
- stroke _____
- peripheral vascular disease _____
- cancer _____
- kidney disease _____
- other _____

HABITS

Smoke? Yes _____ No _____

how many a day _____

Alcohol? Yes _____ No _____

how many drinks a day? _____

SURGERIES

(List surgeries and dates of surgeries)

FAMILY HISTORY

(Heart disease, cancer, etc.- all family)

MEDICATIONS

ALLERGIES

Drugs: _____

Metals: _____

Is there a possibility you could be pregnant? _____

Date & Place of last tetanus shot