General Medical History Worksheet

Check boxes and fill in information as appropriate-use the reverse side if necessary

Name: _____ Date of Birth: _____ Date: _____

Doctor(s) to who reports should be sent: _____

Prior Hospitalizations and Surgical History ☐ No Past Medical History

	Type of Surgery/Reason for Hospitalization	Date	Physican
1.			
2.			
3.			
4.			
5.			

Current Medications (include herbal supplements) ☐ Currently Taking No Medication

	Name of Medication	Dose/Strength	Schedule Taken
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Allergies to Medication or Materials ☐ None Known

	Allergen	Reaction
1.		
2.		
3.		

Social Background

Marital Status: ☐ Married ☐ Domestic Partnership ☐ Single ☐ Divorced ☐ Widowed

Number of children: _____

Do you smoke? ☐ No ☐ Yes – If so, how many packs per day? _____ How many years?_____

Do you drink alcohol? ☐ No ☐ Occasionally ☐ Daily

Do you live with someone who can take care of you at home? ☐ No ☐ Yes

If so, who?_____

(Please complete form on reverse side)

Medical History, Review of Systems, and Family History

Have you or your *immediate* family members have had any of the following conditions?

Please check the box if "yes".

Self	Family		Self	Family	
☐	☐	Osteoarthritis/Degenerative Joint Disease	☐	☐	Migraine Headaches/Frequent Headaches
☐	☐	Inflammatory Arthritis (Rheumatoid, Lupus)	☐	☐	Depression/Anxiety
☐	☐	Gout	☐	☐	Attention Deficit Disorder
☐	☐	Prior Fractures(explain):_____	☐	☐	Sleep Disorders/Sleep Apnea
☐	☐	Problems with Anesthesia	☐	☐	Fibromyalgia/Myofascial Pain
☐	☐	Heart Attack/Heart Disease	☐	☐	Stroke
☐	☐	Chest Pain	☐	☐	Seizures/Epilepsy
☐	☐	Palpitations/Irregular Heartbeat	☐	☐	Fainting/Dizziness
☐	☐	Heart Murmur/Heart Valve Disease	☐	☐	Thyroid Troubles
☐	☐	High Blood Pressure			
			☐	☐	Stomach Problems/Ulcers
☐	☐	Chronic Cough/Pneumonia/Bronchitis	☐	☐	Hepatitis ("Yellow Jaundice")/Liver Disease
☐	☐	Asthma	☐	☐	Diverticulitis
☐	☐	Lung Disease/Emphysema/Short of Breath	☐	☐	Coughing Up Blood
			☐	☐	Black or Bloody Stools
☐	☐	Diabetes/High Blood Sugar			
☐	☐	Urinary Tract Infections/Urinary Troubles	☐	☐	Weight Loss (Unexplained; not diet-related)
☐	☐	Kidney Disease/Dialysis	☐	☐	Unexplained Fever or Shaking Chills
☐	☐	Kidney Stones	☐	☐	Serious or Recurrent Infections (Describe):
☐	☐	High Cholesterol			_____
☐	☐	Circulation Problems/Vascular Disease	☐	☐	HIV/Syphilis/Tuberculosis
☐	☐	Anemia/Bleeding/Hemophilia	☐	☐	Cancer - If "yes", what type:
☐	☐	Blood Clot/Deep Vein Thrombosis			_____
☐	☐	Skin Disease. Give Type: _____	☐	☐	Other Medical Problems (Describe):
					_____
					_____

X_____ _____ **X**_____

Signature of Patient, Parent, or Guardian — Date — Reviewed by MD