Medical History Form

Patient Name:____ **Date:**______________________

Daily Medications: ____

Allergy to Medications: ____

Major Illnesses or Surgeries: ____

Constitutional
☐ Fever
☐ Weight Loss
☐ Developmental Disability
☐ Fatigue
☐ Trauma
☐ Other_______________
Meds_________________
All Above Negative ☐

Ears, Nose & Throat
☐ Upper Respiratory Tract Infection
☐ Other_______________
Meds_________________
All Above Negative ☐

Cardiovascular
☐ Heart Disease
☐ Hypertension
☐ Stroke
☐ Vascular Disease
☐ Other_______________
Meds_________________
All Above Negative ☐

Respiratory
☐ Asthma
☐ Emphysema
☐ Bronchitis
☐ Other_______________
Meds_________________
All Above Negative ☐

Gastrointestinal
☐ Ulcer
☐ Intestinal
☐ Crohn's
☐ Colitis
☐ Digestive
☐ Other_______________
Meds_________________
All Above Negative ☐

Genitourinary
☐ Urinary Tract Infection
☐ STD – Viral Herpetic, Chlamydia
☐ Other_______________
Meds_________________
All Above Negative ☐

Musculoskeletal
☐ Arthritis
☐ Fibromyalgia
☐ Muscular Dystrophy
☐ Osteoarthritis
☐ Ankylosing Spondylitis
☐ Other_______________
Meds_________________
All Above Negative ☐

Integumentary
☐ Skin Cancer
☐ Eczema
☐ Rosaceous
☐ Psoriasis
☐ Other_______________
Meds_________________
All Above Negative ☐

Psychiatric
☐ Anxiety
☐ Depression
☐ Insomnia
☐ Panic Disorder
☐ Schizophrenia
☐ Other_______________
Meds_________________
All Above Negative ☐

Endocrine
☐ Non-insulin Dependent Diabetes
☐ Insulin Dependent Diabetes
☐ Thyroid Dysfunction
☐ Hormonal Dysfunction
☐ Other_______________
Meds_________________
All Above Negative ☐

Allergic/Immunologic
☐ Hay Fever
☐ Drug Allergy
☐ Environmental Allergy
☐ Lupus
☐ Other_______________
Meds_________________
All Above Negative ☐

Hematologic/Lymphatic
☐ Cholesterol
☐ Anemia
☐ Large Volume Blood Loss
☐ Leukemia
☐ Other_______________
Meds_________________
All Above Negative ☐

Neurological
☐ MS
☐ Epilepsy
☐ Other_______________
Meds_________________
All Above Negative ☐

Eyes
☐ Glaucoma
☐ Cataracts
☐ Blindness
☐ Macular Degeneration
☐ Surgery_____________
☐ Inflammatory Disorders
☐ Other_______________
Meds_________________
All Above Negative ☐

Social History
☐ Difficulty When Driving
☐ Do You Smoke
All Above Negative ☐

Family History
☐ Blindness
☐ Glaucoma
☐ Cataracts
☐ Macular Degeneration
☐ Diabetes
☐ Hypertension
☐ Cancer
☐ Heart Disease
☐ Other_______________
All Above Negative ☐

Additional Comments: ____

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