DATE:_____

MEDICAL HISTORY FORM

Patient's Name_____ DOB _____ Age____ Referring Dr._____

Why are you here to see the doctor today?_____

Height _____ Weight _____ Occupation _____

If needed, I consent to the transfusion of any Blood/Blood products ☐ YES ☐ NO

Do you have an active or a history of MRSA/VRE infection: ☐ YES ☐ NO ____Current ____History of

Have you ever been diagnosed with: **C-Diff** ☐ YES ☐ NO **HIV** ☐ YES ☐ NO **Hepatitis B** ☐ YES ☐ NO

Hepatitis C ☐ YES ☐ NO

MEDICATIONS TAKEN REGULARLY	REASON	DOSE	How Often?	Start Date

MEDICINE ALLERGIES	REACTION

MEDICAL PROBLEMS: ex-high blood pressure / diabetes

PAST MEDICAL HISTORY

DISEASE/ILLNESS	YEAR DIAGNOSED	PROCEDURE/SURGERY	YEAR OF PROCEDURE

YOUR FAMILY HISTORY (cancer, heart disease, diabetes, etc. --for mother, father, sister, brother, children)

DIAGNOSIS	FAMILY MEMBER	AGE	COMMENTS

TOBACCO USE: ☐ YES ☐ NO ☐ FORMER

Type _____ Years used _____

Units/day _____ Year quit _____

☐ Current every day smoker ☐ Current someday smoker

☐ Smoker, current status unknown

Passive smoker exposure? ☐ YES ☐ NO

Ever tried to quit? ☐ YES ☐ NO Longest tobacco free: _____ Relapse reason: _____

DRINKS ALCOHOL: ☐ YES ☐ NO ☐ FORMER

Type _____ Amount _____

Frequency _____ Last drink _____

Caffeine ☐ YES ☐ NO Type: _____

EXERCISE: ☐ YES ☐ NO

Can you walk up 2 flights of stairs? ☐ YES ☐ NO