MEDICAL HISTORY FORM

Patient's Name______________________________ DOB __________________ Age_______ Referring Dr.______________________

Why are you here to see the doctor today? ____

Height ____________ Weight ___________ Occupation ____________________________ Pregnant ☐ **YES** ☐ **NO**

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 Y N HIV Y N Hepatitis B Y N Hepatitis C Y N

MEDICATIONS TAKEN REGULARLY	REASON	DOSE	HOW OFTEN	START DATE

MEDICINE/FOOD ALLERGIES	REACTION

MEDICAL PROBLEMS (e.g. high blood pressure, diabetes)

PAST MEDICAL AND SURGICAL HISTORY

DISEASE/ILLNESS	YEAR DIAGNOSED	PROCEDURE/SURGERY	YEAR OF PROCEDURE

YOUR FAMILY HISTORY (e.g. cancer, heart disease, diabetes for maternal/paternal grandparent, parent, sibling, children)

DIAGNOSIS	FAMILY MEMBER	ONSET AGE	CAUSE OF DEATH Y/N	COMMENTS

TOBACCO USE: ☐ YES ☐ NO ☐ FORMER

Type _____________ Years used _____________

Units/day ________ Year quit _______

☐ Current every day smoker ☐ Current someday smoker

☐ Smoker, current status unknown

Ever tried to quit? ☐ YES ☐ NO

Longest tobacco free: ______________ Relapse reason: ______________________________________

Passive smoker exposure? ☐ YES ☐ NO

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