

## Medical History Form

Name \_\_\_\_\_ Age \_\_\_\_ Occupation \_\_\_\_\_

Hobbies \_\_\_\_\_

**Past Medical History:** Please circle any of the following illnesses which you have had.

Angina	Stomach ulcer	Asthma
High blood pressure	Gallbladder disease	Tuberculosis
Heart attack	Colon Disease - type _____	Gout
Heart murmur	Diabetes mellitus	Rheumatoid arthritis
Vascular disease	Thyroid disease	Osteoarthritis
Cancer - type _____	Kidney disease	Lupus
Stroke	Anemia	Bleeding disorder
Seizure disorder	Spinal abnormalities	Headaches
Multiple Sclerosis	Ruptured disc	Hepatitis-type _____
Eye disease -type _____	Pinched nerve	Muscle disease
OTHER _____		

**Please list all previous surgeries:**

Type	Date	Type	Date
_____	_____	_____	_____
_____	_____	_____	_____

**List all medications with dosages you are currently taking:**

_____	_____	_____
_____	_____	_____
_____	_____	_____

**List all medication allergies:** \_\_\_\_\_

### FAMILY HISTORY

Seizures _____	Migraines _____	Stroke _____
Heart disease _____	Dementia _____	Diabetes _____
Neuropathy _____	Muscle disease _____	Parkinson's _____
Other _____		

### SOCIAL HISTORY

**Marital status** (Please circle)    Single    Married    Divorced    Widowed

**Do you drink alcoholic beverages?**    YES    NO

**If yes, what type and on an average, how much per week**

\_\_\_\_\_

**Smoking habits:**    \_\_\_\_\_ YES    \_\_\_\_\_ NO

**What do you smoke and how much?** Past \_\_\_\_\_ Now \_\_\_\_\_