# Medical History

Date: _____

Pt Name: _____

Name of person completing this form _____

How many people live with patient ? Adults _____ Children _____

Birth History: Birth Weight _____ Length_____

During Pregnancy did the patient's mother:

Have any medical problems or complications ? Yes No

If yes, please explain: _____

Smoke tobacco ? Yes No

Drink alcohol? Yes No

Used any drugs or medications ? Yes No

If yes, please explain: _____

Have any problems with labor or delivery ? Yes No

If yes, please explain:_____

Was the delivery: Vaginal Cesarean

## Patient Past Medical History

Overall health is: Good Fair Poor

Allergies to any medication ? Yes No

Name of Medication allergic to _____

Currently taking medication ? Yes No

Name of Medications currently taking _____ _____

_____ _____

Has the patient ever had any problems with any of the following? If yes please explain

| | | | |
|---|---|---|---|
| Eyes/Vision | yes | No | _____ |
| Ears/Nose/Throat | Yes | No | _____ |
| Headaches | Yes | No | _____ |
| Joints/Bones | Yes | No | _____ |
| Seizures | Yes | No | _____ |
| Repeated infections | yes | No | _____ |
| Heart/Lungs | Yes | No | _____ |
| Stomach/Liver | Yes | No | _____ |
| Intestines/Colon | Yes | No | _____ |
| Kidneys/Urine | Yes | No | _____ |
| Indigestion/Nutrition | Yes | No | _____ |
| Anemia/Bleeding | Yes | No | _____ |

Please list surgeries,hospitalizations,serious illness or accidents with dates:

_____ Date _____ _____ Date _____

_____ Date _____ _____ Date _____