Medical History Form – Updated Yearly: Current Date_____
*If additional space is needed for any of the following, use the back of the sheet and indicate that you have done so.*

Name:_____ DOB:_____

**Have you had a flu shot for the most current flu season?** Yes No If Yes, Approximate Date: _____

**Medications You Are Currently Taking** (Include Over The Counter & Herbal Supplements):

| Drug Name | Dose | Drug Name | Dose |
|---|---|---|---|
| _____ | | _____ | |
| _____ | | _____ | |
| _____ | | _____ | |
| _____ | | _____ | |

**Allergies & Reactions:**_____

**Review of Systems** (Chronic Conditions/Symptoms You Are Currently Experiencing):

| | | |
|---|---|---|
| _____High Blood Pressure | _____Indigestion | _____HIV |
| _____Diabetes | _____Change in Weight | _____Breast Lump |
| _____Heart Disease | _____Blood In Stool | _____Frequent Urination |
| _____Chest Pain/Tightness | _____Diarrhea | _____Gallbladder Disease |
| _____Shortness of Breath | _____Constipation | _____Depression |
| _____Asthma | _____Excessive Thirst | _____Headaches |
| _____Hearing Loss | _____Joint Pain | _____Swollen Lymph Nodes |
| _____Ulcers | _____Blood Disorders | _____Skin Diseases |
| _____Change in Bowel Habits | _____Blurred Vision | _____Claustrophobia |

_____Eye Disorders _____Metal In Body – Where?_____

**Personal History**: *Cancer: What Type?_____When?_____

**Other Medical Conditions:**_____

_____

**Hospitalizations and Operations** (Include Reason and Approximate Dates):_____

_____

_____

_____

**Family History:** Has a member of your family ever had the following? (Paternal = Father / Maternal = Mother)

| | **Which Family Member** | P/M? | Alive/Deceased? |
|---|---|---|---|
| Cancer (Include Type)_____ | | P / M | _____ |
| High Blood Pressure _____ | | P / M | _____ |
| Heart Disease_____ | | P / M | _____ |
| Diabetes _____ | | P / M | _____ |
| Stroke _____ | | P / M | _____ |

**Do you smoke**? Yes No If so, how much?_____

**Do you use other tobacco**? Yes No If so, what kind & how much?_____

**Do you drink alcohol**? Yes No If so, how many drinks per week? _____

**For Female Patients**: Are you Pregnant? _____Yes _____ No Are You Breast Feeding? ____ Yes ____ No