Medical History and Assessment Form

Date: ___________Name (Last, First, Middle Initial) ___________________________Date of Birth: ___________

Primary Physician: ___________________________ Address: ____

Office Phone Number:_________________ Date Last Seen: ________________ Date of Last Physical: __________

Past Medical History (Check if You Have Ever Had)

☐ Asthma	☐ Diabetes	☐ Heart Attack	☐ Seizures
☐ Anemia	☐ Emphysema	☐ High Blood Pressure	☐ Stroke
☐ Blood Clots	☐ GERD	☐ High Cholesterol	☐ Thyroid Disease
☐ Congestive Heart Failure	☐ Glaucoma	☐ Kidney Stones	☐ Ulcers
☐ Other:			

Current Medications	Dose	Frequency	Surgeries (List type and date)
1.			1.
2.			2.
3.			3.
4.			4.

Date of Last: Tetanus ______ Flu Vaccine _________ Pneumonia Vaccine ____________ Hep. B Vaccine ________
Medication Allergies: ____
Are you allergic to Latex?_______________

Family History	Father	Mother	Sibling	Other	What Kind
Diabetes					
Cancer					
Heart Disease					
High Blood Pressure					
Death before age 50					
High Cholesterol					

Occupation: _____________________ Employer: _________________________________

Tobacco: ☐ Never Quit in (yr) _______ ☐ Cigars Packs per Day: ☐ < ½ ☐ < 1 ☐ 1 ☐ 1 ½ ☐ > 2 ☐ Chew or Snuff

Alcohol: ☐ Never Drinks per Day ☐ < 1 ☐ 1 ☐ 1 ½ ☐ > 2 Illicit Drugs ☐ No ☐ Yes

Have you recently had any of the following?

Const	☐ Fever	☐Chills	☐ Sweats	☐ Tired	☐ Weight Loss	☐ None
Skin	☐ Rash	☐ Ulcer	☐ Redness	☐ Discoloration	☐ None	
Cardiac	☐ Chest Pain	☐ Light Headed	☐ Swelling Of Legs	☐ None		
Respiratory	☐ Short Of Air	☐ Cough	☐ Sputum	☐ None		
GI	☐ Pain In Abdomen		☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ None
Genito-Urinary	☐ Pain With Urination		☐ Waking Up To Urinate	☐ Incontinence	☐ None	
Eyes	☐ Blurred Vision	☐ Eye Pain	☐ None			
Allergy	☐ Sneezing	☐ Hay Fever	☐ Watering Eyes	☐ None		
Psychological	☐ Depression	☐ Anxiety	☐ Insomnia	☐ None		
Endocrine	☐ Over-Thirsty	☐ Heat Or Cold Intolerance		☐ None		
Musculo-Skeletal	☐ Joint Pain	☐ Muscle Ache	☐ None			
Hematology	☐ Easy Bruising	☐ Blood Clots	☐ Anemia	☐ Bleeding Tendency		☐ None
H/O using Compression Hose	☐ No	☐ Yes	How Long? ________________			

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

____ ___________________________

Signature of Patient or Legal Guardian Date

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