Medical Information Form

Name_____ **Date**_____

Name preferred to be called:_____

List of Doctors:_____

Reason for Visit:_____

Past Medical History: (check all that apply): # Pregnancies_____ # Deliveries_____

- O High Blood Pressure
- O Coronary Artery Disease
- O Heart Attack
- O Tuberculosis
- O Reflux
- O Diabetes Mellitus
- O Insulin Use
- O Pacemaker
- O Lung Disease
- O Asthma
- O Seizures
- O Peripheral Vascular Disease
- O Kidney Disease
- O Cancer
- O Ulcers
- O Stroke
- O Irregular Heart Beat
- O Congestive Heart Failure
- O Hepatitis
- O Thyroid
- O Other:_____

Past Surgery(s):_____

_____

_____

Medications (Doses):_____

_____

_____

Drug Allergies:_____ **Latex Allergy**_____

Alcohol: Yes No Type/Quantity_____ Frequency_____

Smoking Status: Please fill in blanks with when you started, how much, and/or when you quit.

- O Every day:_____
- O Former:_____
- O Some day:_____
- O Never
- O Status unknown
- O Unknown if ever smoked

Drug Use: Yes No Type/Quantity_____ Past Use_____

Height: _____ **Weight:** _____

Family History: If any apply, please state the relationship of the family member.

- O Heart Disease_____
- O Bleeding Disorders_____
- O Diabetes_____
- O Cancer/Type_____
- O Other:_____
- O None_____

System Review:

- O Shortness of Breath
- O Cough
- O Fevers/Chills
- O Dizziness
- O Fatigue/Weakness
- O Nausea/Vomiting
- O Diarrhea
- O Visual Disturbance
- O Hearing Problems
- O Weakness in Extremities
- O Chest Pain
- O Altered Bowel Habits
- O Altered Bladder Habits
- O Poor Appetite/Weight Loss
- O Other

Other medical information you wish to provide_____

_____