

Name _____

DOB _____

Medical / Past Medical History Form

Are you under a physician's care now? Yes or No If yes, who

Are you taking any medications, pills or drugs? Yes or No

Are you allergic to any medications or have any allergies? Yes or No

Do you use tobacco? Yes or No If yes, How many years _____ Packs per day _____

Do you Drink? Yes or No. If Yes, How Much? _____

Do you use controlled substances? Yes or No If yes, which substances

What surgeries or procedures have you had? Surgery and Year

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes or No	Anemia	Yes or No
Anxiety	Yes or No	Juvenile Arthritis	Yes or No
Asthma	Yes or No	Blood Transfusion	Yes or No
Breathing Problems	Yes or No	Cancer	Yes or No
Chest Pains	Yes or No	Diabetes	Yes or No
Epilepsy or Seizures	Yes or No	Excessive Bleeding	Yes or No
Excessive Thirst	Yes or No	Fainting/Dizziness	Yes or No
Frequent Cough	Yes or No	Frequent Diarrhea	Yes or No

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Frequent Headaches Yes or No
Hay Fever Yes or No
Heart Trouble/Disease Yes or No
Hepatitis B Yes or No
High Blood Pressure Yes or No
Kidney Problems Yes or No
Thyroidism Yes or No
ADD/ADHD Yes or No

Genital Herpes Yes or No
Heart Murmur Yes or No
Hepatitis A Yes or No
Hepatitis C Yes or No
High Cholesterol Yes or No
Sickle Cell Disease Yes or No
Venereal Disease/STD Yes or no

Others:

What medical conditions run in your Family? Also state who had the disease:

What grade are you in? _____ How are your grades? _____

Do you have difficulty concentrating? _____

Do you feel safe at school? _____

Do you have friends? _____

If you are stressed out, why? _____

What's your activity level? Low/Medium/High

How do you sleep? Good/Fair/Poor

Are you sexually active? _____

What form of contraception do you use? _____

How many times have you been pregnant? _____ How many times have you delivered a baby _____

What's the reason for your visit?

Name _____

DOB _____

What are you looking for in a doctor?

How did you hear about us?
