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	Genital Herpes	Yes or No
Hay Fever	Yes or No	Heart Murmur	Yes or No
Heart Trouble/Disease	Yes or No	Hepatitis A	Yes or No
Hepatitis B	Yes or No	Hepatitis C	Yes or No
High Blood Pressure	Yes or No	High Cholesterol	Yes or No
Kidney Problems	Yes or No	Sickle Cell Disease	Yes or No
Thyroidism	Yes or No	Venereal Disease/STD	Yes or no
ADD/ADHD	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?_____

Do you use condoms if you are sexually active?_____

What's the reason for your visit?

_____

_____

Name_____
DOB_____

_____
_____

What are you looking for in a doctor?

_____
_____
_____
_____

How did you hear about us?

_____