MEDICAL HISTORY / PERSONAL INFORMATION

Name: | Date: | Chart Number:

Allergies to Medications or Other Substances:

Operations:	Year:	Operations:	Year:
Tonsils		Heart	
Ear Tubes		Hysterectomy	
Appendix		Vasectomy	
Gallbladder		Breast	
Knee/Hip		Bones	

Other Operations: Year Performed

Hospital Stays Other Than Above: Reason and Year

Other Injuries or Fractures: Area Injured and Year

Current Medications: Name and Amount

Habits:	Yes:	Packs per Day:	Start/Quit Year
Cigarettes:			
If Quit:			
Coffee/Pop:		Cups per day:	
Alcohol:		Drinks per day:	
Other Drugs:		Type:	Vape:
Exercise:		Type:	Days/wk:

Number of Living Children: Ages:

Number of Deceased Children: Ages:

Your Living Situation and Who Lives There:

How did you learn about our clinic?

When your blood is taken, do you faint? Y N

Self and Family History:

Cancers: Self or Family: Who? At What Age?

Breast ☐ Colon: ☐

Other Cancers:

	Self:	Father:	Mother:	Brother:	Sister:	Dad's Dad	Dad's Mom	Mom's Dad	Mom's Mom	
	S	F	M	B	S	D	D	M	M	
Headaches										
Stroke/ CVA/TIA										
Eye/Ear Problems										
Neck Pain										
Thyroid										
Hypertension										
Cholesterol										
Heart Attack										
Heart Problem										
Allergies										
Asthma										
COPD										
Liver/Hepatitis										
Diabetes										
Reflux/Intestines										
Low Back Pain										
Leg Problems										
Irreg/Heavy Periods										
Incontinence										
Emotional Problems										
Other										

Family Deaths: Year / Age / Cause of Death

Father

Mother

Brother(s)

Sister(s)

Son(s)

Daughter(s)

Spouse(s)

Life Events: Year:

Single ☐ Married ☐ Yr:

Divorced ☐ Year: Widowed ☐ Yr:

Religion:

Occupation/Retired: Yr:

Military Service: Branch:

Additional information for your Medical Provider: