MEDICAL HISTORY

Name______________________________SS#____________________Birth Date______________

DRUG ALLERGIES

____

____

____

CURRENT MEDS

Prescription: ______________________________

____

Over-the-Counter: ______________________________

IMMUNIZATIONS (YEAR RECEIVED IF KNOWN)

Influenza ______________________________

Pneumonia ______________________________

Hepatitis ______________________________

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Heart Disease	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐
Parkinson's disease	☐	☐	☐	☐	☐	☐
Alzheimer's disease	☐	☐	☐	☐	☐	☐
ALS						

Age at death: ______________________________

Cause of death: ______________________________

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

INJURIES

Reason	Date	Reason	Date

PREVIOUS MEDICAL DIAGNOSES

- ☐ Scarlet fever
- ☐ Rheumatic fever
- ☐ Endocrine disease
- ☐ Venereal disease
- ☐ Thyroid disease
- ☐ Renal disease
- ☐ Liver disease
- ☐ Anemia
- ☐ Gout
- ☐ Stroke
- ☐ Bleeding disorder
- ☐ Arythmia
- ☐ Psoriasis/Eczema
- ☐ Urinary tract disorder
- ☐ Epilepsy
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ COPD
- ☐ Ulcer
- ☐ Cancer
- ☐ Heart Murmur
- ☐ Enlarged prostate
- ☐ Glaucoma/Cataracts
- ☐ MI
- ☐ Orthopnea
- ☐ TB/Lung
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Diabetes
- ☐ Hepatitis
- ☐ TIAs

PREVIOUS MEDICAL SYMPTONS

- ☐ Constipation
- ☐ Incontinence/Bladder
- ☐ Incontinence/Bowel
- ☐ Dizziness
- ☐ Failing episodes
- ☐ Loss of consciousness
- ☐ Fatigue
- ☐ Anxiety
- ☐ Shortness of breath
- ☐ Heart palpitations
- ☐ Digestive problems
- ☐ Hearing loss
- ☐ Sexual dysfunction
- ☐ Chest pain/angina
- ☐ Sleep disorders
- ☐ Depression
- ☐ Hallucination
- ☐ Paranoia

HABITS

Smoke: Packs daily______________ How long: ______________ When stopped:______________

Exercise routine: ______________ Diet: ______________________________

Coffee: Cups daily______________ Alcohol: Type/Amount: ______________ Sleep pattern: ______________

Do you have a Living Will? Y / N

Do you have Power of Attorney? Y / N