Medical History

Medical conditions
List all your current medical conditions and the year in which you were diagnosed:

List any medical conditions that have resolved

Here is a short checklist to help jog your memory and make sure you have a complete list.

❑ Cancer ❑ Heart Attack ❑ Heart Murmur ❑ High Blood Pressure ❑ High Cholesterol ❑ Diabetes ❑ Pneumonia ❑ Asthma ❑ COPD ❑ Broken Bones ❑ Concussion ❑ Seizure ❑ Migraine ❑ Multiple Sclerosis ❑ Stroke/TIA ❑ ADHD ❑ Alcohol Abuse ❑ Anorexia/Bulimia ❑ Anxiety Disorder ❑ Drug Dependency ❑ Depression ❑ HIV/AIDS ❑ Chlamydia ❑ Gonorrhea ❑ Genital Herpes ❑ Thyroid Disease ❑ Chronic Kidney Disease ❑ Kidney Stones ❑ Glaucoma ❑ Cataracts ❑ Anemia ❑ Bleeding Disorder ❑ Blood Clot/Clotting Disorder ❑ Polycystic Ovary Syndrome ❑ Hearing Loss ❑ Hay Fever ❑ Eczema ❑ Recurrent Sinus Infections ❑ Celiac Disease ❑ Irritable Bowel Syndrome ❑ Stomach Ulcer ❑ Ulcerative Colitis ❑ Crohn's Disease ❑ Polyps in Colon ❑ Arthritis

Surgeres
List your prior surgeries

Here is a short checklist to help you make a complete list
- (Date: _____) Appendectomy
- (Date: _____) Adenoidectomy
- (Date: _____) Ear Tubes
- (Date: _____) Gallbladder Removal
- (Date: _____) Knee ACL Repair (Left/Right)
- (Date: _____) Knee Arthroscopy (Left/Right)
- (Date: _____) Ovarian Cyst Removal
- (Date: _____) Tonsillectomy
- (Date: _____) Weight Loss Surgery
- (Date: _____) Other Prior Surgeries

Medical History

Medications

List all medications that you are currently taking, including the dosage and start date. It might be helpful to note if you need refills as a reminder for your next visit.

List any supplements, herbs, and natural health products:

Are you allergic to any medications? If yes, which ones?

Medical History

Family History

This chart helps you keep track of major diseases in your blood relatives.

	Mother	Father	Siblings	Grandparents
Alcoholism				
Blood Clots/Clotting Disorders				
Breast Cancer				
Colon Cancer				
Melanoma				
Other Cancer				
Diabetes				
Drug Dependency				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Mental Illness				
Other Conditions				

Medical History

Family History
List any other significant family history in your first-degree relatives:

Biological mother

Biological father

Siblings

List any significant family history in your second-degree relatives (uncles/aunts, grandparents):

Women's Health History

Date of last menstrual cycle

Age at first menstruation

Age at menopause

Total number of pregnancies

Number of live births

Pregnancy complications

Last pap smear

Sexual History

Are you sexually active? If yes, with men or women? Or with both?

How many active partners do you have?

Do you use contraception? If yes, what kind?

Do you have any sexual issues to discuss?

Medical History

Social History

Do you smoke tobacco? If yes, how many cigarettes per day?

Do you use e-cigarettes? If yes, how many times per day?

Do you drink alcohol? If yes, how many drinks per week?

Do you drink caffeinated beverages? If yes, what type (coffee/tea/soda), and how many per day?

Do you use recreational drugs? If yes, what type and how often?

Do you exercise regularly? How many minutes per week on average?

Do you get enough sleep? Do you feel rested when you wake up?

Who else lives in the home with you?

What kind of work do you do?

Have you traveled in the last year? If yes, where?

Is there any relationship between your experiences at work, travel, or home and the symptoms you have?

What is your highest education level?