

MEDICAL HISTORY

Name _____ SS # _____ Birth Date _____

DRUG ALLERGIES

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SYBLINGS	CHILDREN
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age at death	_____					
Cause of death	_____					

CURRENT MEDS

Prescription: _____

Over-the-Counter: _____

IMMUNIZATIONS (YEAR LAST RECEIVED IF KNOWN)

Influenza _____
 Pneumonia _____
 Hepatitis _____

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

INJURIES

Description	Date	Description	Date

PREVIOUS MEDICAL DIAGNOSES

- | | | |
|--|---|---|
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Enlarged prostate |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Psoriasis / Eczema | <input type="checkbox"/> Glaucoma / Cataracts |
| <input type="checkbox"/> Endocrine disease | <input type="checkbox"/> Urinary tract disorder | <input type="checkbox"/> MI |
| <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Orthopnea |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Allergies | <input type="checkbox"/> TB / Lung |
| <input type="checkbox"/> Renal disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hyperlipidemia |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> TIAs |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Heart murmur | |

PREVIOUS MEDICAL SYMPTOMS

- | | | |
|---|--|--|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Incontinence / Bladder | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Chest pain / angina |
| <input type="checkbox"/> Incontinence / Bowel | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sleep disorders |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Fainting episodes | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Hallucination |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> 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 a Power of Attorney? Y / N