MEDICAL HISTORY FORM

Name: _____ **DOB**:_____ **Age**: _____ **Date:** _____

Reason of Visit: _____

Problem	**Year of Diagnosis**	**Problem**	**Year of Diagnosis**	**Surgeries**	**Year**
Diabetes		Hypothyroidism			
High Blood pressure		Hyperthyroidism			
High cholesterol		Thyroid Nodule			
Heart attack		Thyroid Cancer			
Stroke		Osteoporosis			
Kidney disease		Vitamin D deficiency			
Polycystic ovarian syndrome		High Calcium levels			
Pituitary Tumor		Low testosterone			
Cancer of		Other:			

Drug Allergies:(List)

_____

Medications: List any medications you are currently taking with dosage(include over the counter herbal/vitamin medications).

1._____ 5._____ 9_____

2. _____ 6._____ 10_____

3._____ 7._____ 11_____

4._____ 8._____ 12_____

ADOPTED YES or NO **If you are adopted you do not have to complete the following family medical history**

Family member	**Alive/ Deceased**	**Diabetes**	**Thyroid disease**	**Heart disease**	**High blood pressure**	**Osteoporosis**	**Cancer**	**Other**
Mother								
Father								
Brother 1								
Brother 2								
Sister 1								
Sister 2								
Grandfather (pat)								
Grandfather(mat)								
Grandmother(pat)								
Grandmother(mat)								
Other								

Social Occupation: _____ Circle: Married Divorced Widowed Single

Children: No Yes Pregnancies: _____ Miscarriages_____

Exercise: No Yes Hours per week: _____

Smoke: _No Yes Alcohol: No Yes How much per week? _____