Medical History

When visiting a doctor, especially for the first time, it is helpful to prepare your medical history in advance. Your healthcare team needs as much information as possible so they can determine the care that is best for you. Your healthcare team may have specific forms for you, but these will help you collect basic information you will need before your appointments.

BASIC INFORMATION

Name: _____

Birthdate: _____

Phone Number(s): _____

Address: _____

Social Security Number: _____

Employer: _____

Spouse's Name: _____

Spouse's Phone Number: _____

Emergency Contact: _____

Emergency Contact's Phone Number(s): _____

PRIMARY CARE DOCTOR

Primary Care Doctor: _____

Practice: _____

Phone Number: _____

Address: _____

INSURANCE INFORMATION

Be sure to take all insurance and prescription cards with you to your appointment.

Insurance Provider: _____

Account Number: _____

Policy Holder's Name: _____

Patient's Relation to Insured: _____

Secondary Insurance Provider: _____

Account Number: _____

Policy Holder's Name: _____

Patient's Relation to Insured: _____

Policy Holder's Employer: _____

Employer Address: _____

Employer Phone Number: _____

PAST MEDICAL HISTORY

In the past, have you been diagnosed with any of the following? **Check all that apply.**

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cancer
- ☐ Colitis
- ☐ Concussions
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Impaired Mobility
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Migraines
- ☐ Other STDs
- ☐ Urinary Tract Infections
- ☐ Other: _____

List any surgeries, imaging, hospitalizations, or other major procedures you've had in the past.

Procedure	Description/Purpose	Date

FAMILY MEDICAL HISTORY

Has anyone in your family experienced any of the following? If so, who?

	RELATION
Asthma	
Blood Clots	
Cancer (List Cancer Type)	
Depression	
Diabetes	
Heart Disease	
High Blood Pressure	
High Cholesterol	
Blood Clots	
Low Blood Pressure	
Kidney Disease	
Lung Disease	
Irritable Bowel Syndrome	
Liver Disease	
Colitis	
AIDS/HIV	
Other	

Do you know any other pertinent family medical history?

CURRENT MEDICATIONS AND ALLERGIES

Please list all current medications, including any vitamins, supplements, or over-the-counter medications.

Medication Name	Dosage/Frequency	Reason Taken

LIST ALL ALLERGIES

List all allergies including medications, foods, and substances.

MY PHARMACY

Pharmacy Name: _____

Phone Number: _____

Address: _____