MEDICAL HISTORY

Visit **www.LLSnutrition.org/worksheets/** to access all worksheets.

When visiting a doctor, especially for the first time, it is helpful to prepare the your medical history in advance. The members of the healthcare team need as much information as possible so that they can determine the best care plan. The doctor's office may have specific forms, but these will help you collect the basic information needed before the appointment.

Patient's Information

Name: _____

Date of Birth (DOB): _____

Phone Number(s): _____

Address: _____

Social Security Number: _____

Employer: _____

Spouse's Name: _____

Spouse's Phone Number(s): _____

Emergency Contact: _____

Emergency Contact's Phone Number(s): _____

Primary Care Provider (PCP)

Primary Care Provider: _____

Practice Name: _____

Phone Number(s): _____

Fax Number: _____

Address: _____

Insurance Information

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

Insurance Provider: _____

Account Number: _____ Group Number: _____

Policy Holder's Name and Date of Birth: _____

Patient's Relationship to Insured: _____

Secondary Insurance Provider: _____

Account Number: _____ Group Number: _____

Policy Holder's Name and Date of Birth: _____

Patient's Relationship to Insured: _____

Policy Holder's Employer: _____

Employer Address: _____

Employer Phone Number(s): _____

Past Medical History

In the past has the patient been diagnosed with any of the following? Check all that apply.

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots (for example, thrombosis)
- ☐ Cancer
- ☐ Colitis
- ☐ Concussion
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol Level
- ☐ HIV/AIDS
- ☐ Impaired Mobility
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Migraines
- ☐ Sexually Transmitted Diseases (STDs)
- ☐ Urinary Tract Infection
- ☐ Other: _____

List any previous surgeries, imaging, hospitalizations or other major procedures.

PROCEDURE	DESCRIPTION/PURPOSE	DATE

Family Medical History

Has anyone in the patient's family experienced any of the following? If so, who?

DISEASE	RELATIONSHIP
Asthma	
Blood Clots (for example, a thrombosis)	
Cancer (List Types)	
Depression	
Diabetes	
Heart Disease	
Hepatitis	
High Blood Pressure	
High Cholesterol Level	
Low Blood Pressure	
Kidney Disease	
Lung Disease	

Irritable Bowel Syndrome	
Liver Disease	
Colitis	
HIV/AIDS	
Other	

Please provide any other family medical history

_____

_____

Current Medications and Allergies

Please list all the medications the patient is taking. Include any vitamins, supplements or over-the-counter medications.

MEDICATION NAME	DOSAGE/FREQUENCY	REASON TAKEN

List all allergies to medications, foods, and any other substances:

_____

Pharmacy

Pharmacy Name: _____

Phone Number(s): _____

Fax Number: _____

Address: _____