MEDICAL HISTORY

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When visiting a doctor, especially for the first time, it is helpful to prepare your medical history in advance. Your 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: ______________________________

Health Number: ______________________________

Employer: ______________________________

Spouse's Name: ______________________________

Spouse's Phone Number(s): ______________________________

Emergency Contact: ______________________________

Emergency Contact's Phone Number(s): ______________________________

Primary Care Provider/ Family Physician

Primary Care Provider: ______________________________

Practice Name: ______________________________

Phone Number(s): ______________________________

Fax Number: ______________________________

Address: ______________________________

Extended Health Insurance Information

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

Please 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
- ☐ Impaired Mobility
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Migraines
- ☐ Urinary Tract Infection

Other:

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

PROCEDURE	DESCRIPTION/PURPOSE	DATE

Family Medical History

Has anyone in your 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	
Other	

Please provide any other family medical history

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Current Medications and Allergies

Please list all the medications you are 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:

MEDICATION	ALLERGY

Pharmacy

Pharmacy Name: ____

Phone Number(s): ____

Fax Number: ____

Address: ____