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Medical Content Reviewed by the Faculty of the **Harvard Medical School**

## MEDICAL HISTORY FORM

Complete this form *before* going to the doctor, especially if this is your first visit.

### Personal Information

Name:

Date:

### Emergency Contact

Name:

Relationship:

Phone number:

### Insurance Information

Insurance carrier:

Policy number:

### Health Information

List any other physicians who are treating you.

Name	Specialty	Phone

What are the major concerns for your visit today?

- 1)
- 2)
- 3)
- 4)

Your Medical History

List all of the conditions for which you have received medical treatment, either now or in the past.

- |    |    |
|----|----|
| 1) | 5) |
| 2) | 6) |
| 3) | 7) |
| 4) | 8) |

List any surgical procedures (major or minor) you have undergone.

Procedure:	Date:
Procedure:	Date:
Procedure:	Date:

List all of the times you have been hospitalized.

Date:	Reason:
Date:	Reason:
Date:	Reason:

List any medications that you currently take (include prescription drugs, over-the-counter treatments, vitamins, etc.). And list the doses, if known.

Drug:	Dose:
Drug:	Dose:
Drug:	Dose:
Drug:	Dose:
Drug:	Dose:
Drug:	Dose:

List any allergies or bad reactions you have had to medications.

Drug:	Reaction:
Drug:	Reaction:
Drug:	Reaction:

When was your most recent tetanus vaccination?

Have you ever had influenza (flu) vaccine?

Yes (provide date): No

Have you ever had tuberculosis (TB) or a positive skin test for tuberculosis?

Yes (provide date): No

Have you ever had any of the following vaccinations?

- Pneumococcal (pneumonia) vaccine

Yes (provide date): No

- Hepatitis A vaccine

Yes (provide date): No

- Hepatitis B vaccine

Yes (provide date): No

- Bacille Calmette-Guerin (BCG) vaccine (for tuberculosis)

Yes (provide date): No

- Lyme disease vaccine

Yes (provide date): No

- Meningococcal vaccine

Yes (provide date): No

When was your most recent cholesterol test, and what were the results (approximately)?

Have you ever undergone a screening test for colon cancer (sigmoidoscopy or colonoscopy)?

Yes (provide date): No

Do you now or have you ever used tobacco?

Do you drink alcohol?

For Women

Date of last menstrual period:

Previous pregnancies:

Date of last Pap smear:

Date of last mammogram:

### Your Family History

Relative	Alive?	Age (or age at death)	Medical problems*
Mother			
Father			
Brother/sister			
Brother/sister			
Brother/sister			
Brother/sister			
Mother's mother			
Mother's father			
Father's mother			
Father's father			

\*Include heart disease, hypertension, diabetes, stroke, kidney problems, cancer (breast, lung, prostate, liver, colon, ovarian, uterine, cervical), thyroid disease, alcoholism or drug abuse, depression or anxiety, osteoporosis and arthritis

### Systems Review

Circle any problems you may be experiencing and give details below:

Abdominal pain

Ankle swelling

Anxiety or stress

Back pain

Bleeding in bowel movements

Breast lumps

Burning or difficulty passing urine

Chest pains or heaviness

Constipation

Cough

Dental problems

Depression

Diarrhea

Difficulties with vision

Difficulty breathing or shortness of breath

Difficulty swallowing

Difficulty with sexual function

Dizzy spells

Dry or red eyes	Dry mouth	Easy bruising or bleeding
Fatigue	Fevers or chills	Fluid leaking from nipples
Frequent falls or unsteadiness	Frequent urination	Gas
Goiter	Headaches	Hearing problems
Indigestion or heartburn	Irregular menstrual periods	Joint pains or swelling
Loss of appetite	Loss of bladder control	Low sexual drive
Moles or worrisome spots on skin	Nausea or vomiting	Numbness or tingling
Palpitations	Panic attacks	Poor memory
Poor sleep	Rash	Seasonal allergies
Sinus infections or stuffiness	Stiff neck	Swollen glands
Weakness	Weight loss or gain	Wheezing

Details:

**FOLLOW-UP**

Complete this portion of the form *during or after* your visit with your doctor.

Blood pressure: \_\_\_\_/\_\_\_\_

Weight: \_\_\_\_\_

Results of your physical examination:

\_\_\_Normal

\_\_\_ Abnormal

What tests (if any) did your doctor perform or order today?

Blood tests

Stress test

Urinalysis

Echocardiogram

X-rays

Biopsy

Electrocardiogram (ECG)

Pap smear

Stool cards

Bone density

Sigmoidoscopy

Colonoscopy

Mammogram

Other

When and how will you receive your results?

Did your doctor refer you to any other health professionals?

Name:

Telephone number:  
Specialty:  
Date of appointment:

Your Doctor's Recommendations

Changes in medication:

Changes in diet or exercise:

Preventive tests or treatment:

When is your next doctor's visit?

Date:  
Time:

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