Patient Medical History Form

Directions: Your teacher will tell you about a patient. With your class, fill out this form with the patient's information.

1. Date of last medical exam (month, year) _____

2. Have you ever been hospitalized for surgery or serious illness? Yes ___ No ___
If yes,

Date	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Are you taking any medications (prescriptions or over-the-counter) regularly?

Yes _____ No _____ If yes, what medications are you taking?

_____

_____

_____

_____

4. Do you wear glasses or contact lenses? Yes _____ No _____

5. Are you allergic to any medication or have you had any reactions?

Yes _____ No _____ If yes, fill out the chart below.

Name of Medication	Reaction	When

Patient Medical History Form, continued

6. Are you allergic to anything else (food, pollen, dust, etc.)? Yes ____ No _____

7. Do you have or have you had any of the following:

a.	arthritis	Yes _____	No _____
b.	diabetes	Yes _____	No _____
c.	hypertension/high blood pressure	Yes _____	No _____
d.	high cholesterol	Yes _____	No _____
e.	mental illness	Yes _____	No _____
f.	kidney disease	Yes _____	No _____
g.	osteoporosis	Yes _____	No _____
h.	sexual/physical abuse	Yes _____	No _____
i.	thyroid disease	Yes _____	No _____
j.	HIV/AIDS	Yes _____	No _____
k.	heart disease/heart attack	Yes _____	No _____
l.	substance abuse	Yes _____	No _____
m.	alcoholism	Yes _____	No _____
n.	asthma	Yes _____	No _____
o.	seizures	Yes _____	No _____
p.	stroke	Yes _____	No _____
q.	anemia/blood diseases	Yes _____	No _____
r.	liver diseases	Yes _____	No _____
s.	immune problems	Yes _____	No _____
t.	cancer	Yes _____	No _____
u.	frequently tired	Yes _____	No _____
v.	recent weight loss	Yes _____	No _____
w.	other:		

_____

_____

Patient Medical History Form, continued

8. For Women Only

pregnancies _____ # live births _____

Date of last Pap Smear _____ Date of last Mammogram _____

Age periods began _____ First day of last period _____

Do you use birth control? Yes _____ No _____

If yes, what kind? _____