Medical History

Name ______________________ **DOB:** ______________

Current Medications, Supplements/Vitamins

Medication	Strength	Dose	Purpose

Medical History (Please check all that apply)

☐ Allergies	☐ Emphysema/COPD	☐ High Cholesterol	☐ Sexually Transmitted Disease
☐ Anemia	☐ Enlarged Prostate	☐ Incontinence	☐ Shortness of Breath
☐ Anxiety	☐ Gall Stones	☐ Irritable Bowel Syndrome	☐ Skin Condition
☐ Arthritis	☐ Gout	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Headaches	☐ Kidney Stones	☐ Thyroid Disease
☐ Blood Clots	☐ Heart Disease	☐ Liver Disease	☐ Ulcers
☐ Cancer Type: _______	☐ Hepatitis: Type:_______	☐ Osteoporosis	☐ Vision Loss
☐ Depression	☐ Hearing Loss	☐ Pneumonia	☐ Other: ____________
☐ Diabetes	☐ High Blood Pressure	☐ Seizures	☐ Other: ____________

Allergies (List all Allergies and Sensitivities)

Allergy:______________ Reaction: ______________________________

Allergy:______________ Reaction: ______________________________

Allergy:______________ Reaction: ______________________________

Allergy:______________ Reaction: ______________________________

Allergy:______________ Reaction: ______________________________

Past Surgeries

Year:____________ Procedure: ______________________________

Year:____________ Procedure: ______________________________

Year:____________ Procedure: ______________________________

Year:____________ Procedure: ______________________________

Year:____________ Procedure: ______________________________

Medical History

CareATC

Name ______________________ **DOB:** ____________

Hospitalizations

Year:____________ Reason:______________________________

Year:____________ Reason:______________________________

Year:____________ Reason:______________________________

Year:____________ Reason:______________________________

Year:____________ Reason:______________________________

Family Medical History (Please list all medical conditions for the following)

Father ☐ Living ☐ Deceased ______________________

Mother ☐ Living ☐ Deceased ______________________

Sibling ☐ Living ☐ Deceased ______________________

Sibling ☐ Living ☐ Deceased ______________________

Children ☐ Living ☐ Deceased ______________________

Other ☐ Living ☐ Deceased ______________________

Social History

Exercise: ☐ None Frequency ____________

Tobacco Use: ☐ None Frequency ____________ Years of Use ____________

Type: ☐ Cigarettes ☐ Smokeless / Chew ☐Cigars

Alcohol Use: ☐ None Frequency ____________

Recreational Drugs: ☐ None Frequency ____________ Type____________ Method____________

Sexually Active: ☐ Yes ☐ No Method of Contraception ____________

Annual Examinations

Procedure	Month/Year	Location Performed
Pap Smear		
Mammogram		
Colorectal Cancer Screening		
Prostate Exam		
COVID Vaccine		
Flu Vaccine		
Tetanus Vaccine		
PHA Exam		

Patient Signature (or Representative if Minor) Date

Relationship to Patient