

HEALTH HISTORY FORM

Today's Date: _____		Primary Care Provider / Address: _____	
PATIENT INFORMATION			
Last Name: _____		First Name: _____ Middle Initial: _____	
Address: _____		Date of Birth: ____/____/____ Phone #: _____	
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Arabic <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Mandarin <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Other			
Race: <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> African American or Black <input type="checkbox"/> Native Hawaiian/Other Pacific <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other			
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino			
Primary Pharmacy: _____		Address: _____	
Prescription Benefits Provided By (i.e. Express Scripts, Medco, etc.): _____			

REASON FOR TODAY'S VISIT			
Concern: _____	Location: _____	Duration: _____	Prior Treatments: _____
Concern: _____	Location: _____	Duration: _____	Prior Treatments: _____

PAST MEDICAL HISTORY			
CRITICAL INFORMATION		MEDICAL HISTORY	
Adhesive tape / latex allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal moles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anticoagulant treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal scars	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acne	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Actinic keratosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bacitracin / Neosporin allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast cancer / Other cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epinephrine sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting / syncope	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	HSV / cold sore	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV positivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Immunosuppressive therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Local anesthetics allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lymphoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor wound healing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Memory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral valve prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rosacea	<input type="checkbox"/> Yes <input type="checkbox"/> No
MRSA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seasonal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Organ transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker / defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Warts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pre-op/pre-dental antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (specify below)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medical History Form Template

Sabine Zange



Medical History Form Template:

This book delves into Medical History Form Template. Medical History Form Template is a vital topic that must be grasped by everyone, from students and scholars to the general public. The book will furnish comprehensive and in-depth insights into Medical History Form Template, encompassing both the fundamentals and more intricate discussions.

1. The book is structured into several chapters, namely:

- Chapter 1: Introduction to Medical History Form Template
- Chapter 2: Essential Elements of Medical History Form Template
- Chapter 3: Medical History Form Template in Everyday Life
- Chapter 4: Medical History Form Template in Specific Contexts
- Chapter 5: Conclusion

2. In chapter 1, this book will provide an overview of Medical History Form Template. This chapter will explore what Medical History Form Template is, why Medical History Form Template is vital, and how to effectively learn about Medical History Form Template.

3. In chapter 2, the author will delve into the foundational concepts of Medical History Form Template. This chapter will elucidate the essential principles that need to be understood to grasp Medical History Form Template in its entirety.

4. In chapter 3, this book will examine the practical applications of Medical History Form Template in daily life. This chapter will showcase real-world examples of how Medical History Form Template can be effectively utilized in everyday scenarios.

5. In chapter 4, the author will scrutinize the relevance of Medical History Form Template in specific contexts. The fourth chapter will explore how Medical History Form Template is applied in specialized fields, such as education, business, and technology.

6. In chapter 5, this book will draw a conclusion about Medical History Form Template. This chapter will summarize the key points that have been discussed throughout the book.

The book is crafted in an easy-to-understand language and is complemented by engaging illustrations. It is highly recommended for anyone seeking to gain a comprehensive understanding of Medical History Form Template.

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