Morris Family Healthcare
&
Wellness

PATIENT HISTORY

PLEASE PRINT USING BLACK OR BLUE PEN ONLY

Patient's Name: (Last) ________________________ (First)____________________(M.I.)_______ Date of Birth: ___/___/_____

This form is being completed by: Patient Spouse Parent Guardian Other

MEDICATION HISTORY - *Please include prescription drugs, and drugs you buy over the counter.*

	Medication	Dose/Strength	When do you take it?	Reason you take the medication
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

ALLERGIES - *List any allergies you have and what type of allergic reaction you experience.*

Latex Allergy	No	Yes	Allergic to:	Reaction:
Medication Allergy	No	Yes	Allergic to:	Reaction:
			Allergic to:	Reaction:
Other Allergies	No	Yes	Allergic to:	Reaction:

PAST SURGICAL HISTORY

Year	Hospital/Location	Reason

Have you or a relative ever had any problems with Anesthesia? No Yes

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PATIENT HISTORY

YOUR PERSONAL MEDICAL HISTORY

	No	Yes		No	Yes		No	Yes
ADD/ADHD			Esophageal Reflux (GERD)			Osteoarthritis		
Anemia			Glaucoma			Osteoporosis		
Alzheimer’s			Gout			Parkinson’s		
Asthma			Heart Attack / Disease			Psoriasis		
Anxiety			Heart Palpitations			Pulmonary Embolism		
Bipolar			Hepatitis A, B, or C			Rheumatoid Arthritis		
Bladder Control Problems			High Blood Pressure			Sciatica		
Bladder Infections			HIV			Shingles		
Bleeding Disorder			Kidney Disease			Seizures		
Blood Clots (DVT)			Liver Disease			Stomach Ulcers		
Cancer			Lung Disease			Stroke/TIA		
Depression			Lupus Erythematosus			Thyroid Disease		
Diabetes			Migraine Headache			Tuberculosis		
Emphysema/COPD			Multiple Sclerosis			Varicose Veins		

Any other medical problems not listed? ____

SOCIAL HISTORY

Marital status: Married Single Widowed Divorced Separated Significant Other

Smoking:

Has never smoked Former smoker Exposure to passive smoke

Currently smokes Has been advised to quit No exposure to passive smoke

No. of packs per day______________ No. of years ________________

Alcohol:

Drinks alcohol No. of Drinks per day_______________ Does not drink alcohol

Drugs:

Are you taking any unprescribed drugs, including recreational drugs? No Yes

If yes, please specify:____

Exercise:

Exercises regularly? No Yes

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PATIENT HISTORY

YOUR FAMILY MEDICAL HISTORY (PARENTS, SIBLINGS AND OTHER RELATIVES)

	Father Mother Sibling Other		Father Mother Sibling Other		Father Mother Sibling Other
Alzheimer's		Glaucoma		Osteoarthritis	
Anemia		Gout		Osteoporosis	
Anxiety		Heart Attack / Disease		Parkinson's	
Asthma		Hepatitis A, B, or C		Pulmonary Embolism	
Bipolar		High Blood Pressure		Psoriasis	
Bleeding Disorder		HIV		Rheumatoid Arthritis	
Blood Clots (DVT)		Kidney Disease		Shingles	
Cancer		Liver Disease		Seizures	
Cancer		Lung Disease		Stroke/TIA	
Depression		Lupus Erythematosus		Thyroid Disease	
Diabetes		Migraine Headache		Tuberculosis	
Emphysema/COPD		Multiple Sclerosis		Varicose Veins	

If other please list whom: ______________________________

Any other medical problems not listed? ______________________________

Other Providers

Provider Name	Provider Specialty

CERTIFICATION BY PATIENT OR RESPONSIBLE PARTY

I have reviewed the information on this form. I certify that all information given is accurate and complete to the best of my knowledge.

Patient's or Responsible Party's Signature: ______________________________ Date: ______________