Douglas Family Medicine
Medical History Form

Patient Name_____ Today's Date_____
Medical History (examples include Diabetes, High blood pressure, Cancer)

_____ _____
_____ _____
Surgical History (please include any broken bones and approximate dates)

_____ _____
_____ _____
Allergies (please list reaction type)

☐ Penicillin ☐Sulfa ☐ Latex ☐ Tape ☐ Other _____
☐ Rash/Hives ☐ Shortness of breath ☐ Stomach pains ☐ Anaphylactic ☐ Other _____

Medications currently taking (please include herbals and over the counter medications)
(please include dose if known, use back of sheet if necessary)

_____ _____
_____ _____

Family History ☐ Diabetes ☐ Heart Disease ☐ Kidney Disease ☐ Cancer
☐ Other _____

Do you use tobacco? ☐ Yes ☐ No If so, how much? _____
Have you ever used tobacco? ☐ Yes ☐ No When did you quit? _____
Do you drink alcohol? ☐ Yes ☐ No If yes, how often? _____
Do you use marijuana? ☐ Yes ☐ No
Do you use recreational drugs? ☐ Yes ☐ No

Please check any other personal medical history:
Eyes, Ears, Nose and Throat
☐ Eyeglasses/Contacts ☐ Dizzy Spells ☐ Conjunctivitis ☐ Sinus Infection ☐ Nose bleeds
Head and Neck
☐ Neck Pain ☐ Headache ☐ Migraine
Extremities
☐ Numbness/Tingling ☐ Ulcers ☐ Varicose Veins ☐ Discoloration
Musculoskeletal
☐ Arthritis ☐ Fibromyalgia ☐ Joint Pain ☐ Back Pain ☐ Tremors ☐ Swelling ☐ Muscular Weakness
Neurologic
☐ Anxiety ☐ Seizures ☐ Depression
Cardiovascular
☐ Chest Pain ☐ Heart Attack ☐ Heart Disease ☐ High Blood Pressure ☐ Rheumatic Fever
☐ Heart Murmurs
Respiratory
☐ Asthma ☐ Emphysema ☐ Shortness of Breath
Endocrine
☐ Thyroid Disease ☐ Diabetes ☐ Gout ☐ Anemia ☐ Blood Clotting Problems
Gastrointestinal
☐ Heartburn ☐ Constipation ☐ Diarrhea ☐ Increased Appetite
Genitourinary
☐ Increased Urination Frequency ☐ Kidney Stones ☐ Nephropathy