West Trenton Medical Associates

MEDICAL HISTORY FORM

Patient Name:_____Age:_____Height:_____Weight_____

Allergies to Medications, Foods, Insects? NO YES Please List:_____

Pharmacy Name and Phone#_____

Current List of ALL Medications (Including strength and exact dosage):

_____

_____

_____

Immunizations: Tetanus:_____Flu:_____Pneumonia:_____Other:_____

Personal Medical History: (Check if you have or have had any of the following)

☐ Anemia	☐ Eye Problems	☐ HIV	☐ Osteoporosis
☐ Cancer	☐ Heart Disease	☐ Kidney Disease	☐ Stroke
☐ Circulatory problems	☐ Hepatitis	☐ Lung Disease	☐ Thyroid Disease
☐ Diabetes	☐ High Blood Pressure	☐ Mental Illness	☐ Tuberculosis

Surgical History: (List all surgeries and year they were performed)

_____

_____

_____

Family History: Relationship Relationship

☐ Cancer_____ ☐ High Blood Pressure_____
☐ Diabetes_____ ☐ Mental Health_____
☐ Heart Disease_____ ☐ Other_____

Social History/Habits:

Smoking: (packs per day)_____ Former smoker (date quit)_____

Alcohol: (amount per week)_____ Substance Abuse:_____

Sexually Active? YES NO Contraceptive Use? YES NO

Completed by:_____ Date:_____

Relationship (if other than patient)_____