WORKSHEET 7

MEDICAL HISTORY

When visiting a doctor, especially for the first time, it is helpful to prepare the patient's medical history in advance. The members of the healthcare team need as much information as possible so that they can determine the best treatment plan. The doctor's office may have specific forms, but this worksheet will help you collect the basic information needed before the appointment so all of the information is in one place.

Patient's Information

Name: _____

Date of Birth (DOB): _____

Social Security Number: _____

Emergency Contact: _____

Emergency Contact's Phone Number(s): _____

Other Adult Contacts

Name: _____

Phone Number: _____

Email: _____

Primary Care Provider (PCP)/Pediatrician

Primary Care Provider: _____

Practice Name: _____

Phone Number(s): _____

Fax Number: _____

Address: _____

Email: _____

Insurance Information

Be sure to take all insurance and prescription cards with you to the appointment.

Insurance Provider: _____

Account Number: _____ Group Number:_____

Policy Holder's Name and Date of Birth: _____

Patient's Relationship to Insured: _____

Secondary Insurance Provider: _____

Account Number: _____ Group Number: _____

Policy Holder's Name and Date of Birth: _____

Patient's Relationship to Insured: _____

Policy Holder's Employer: _____

Employer Address: _____

Employer Phone Number(s): _____

Medical History

In the past has the patient been diagnosed with any of the following? Check all that apply.

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots (For Example, Thrombosis)
- ☐ Cancer

Type: _____

- ☐ Colitis
- ☐ Concussion
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol Level
- ☐ HIV/AIDS
- ☐ Impaired Mobility
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Migraines
- ☐ Sexually Transmitted Diseases (STDs)
- ☐ Urinary Tract Infection
- ☐ Other: _____

List any previous surgeries, imaging, hospitalizations or other major procedures.

PROCEDURE	DESCRIPTION/PURPOSE	DATE

Family Medical History

Has anyone in the patient's family experienced any of the following? If so, who?

DISEASE	RELATIONSHIP
Asthma	
Blood Clots (Thromboses)	
Cancer (List Types)	
Depression	
Diabetes	
Heart Disease	
Hepatitis	
High Blood Pressure	
High Cholesterol Level	
Low Blood Pressure	
Kidney Disease	
Lung Disease	

Irritable Bowel Syndrome	
Liver Disease	
Colitis	
HIV/AIDS	
Other	

Please provide any other family medical history.

_____

_____

Medications and Allergies

Please list all the medications the patient is taking. Include any vitamins, supplements or over-the-counter medications.

MEDICATION NAME	DOSAGE/FREQUENCY	REASON TAKEN

List all allergies to medications, foods and any other substances.

_____

Pharmacy

Pharmacy Name: _____

Phone Number(s): _____

Fax Number: _____

Address: _____