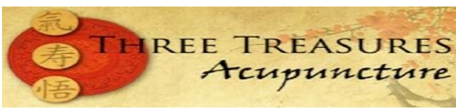


(630) 664-1089
799 Roosevelt Rd, Building 2, Suite 103
Glen Ellyn, IL 60137

MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release it. Please print and complete all information.

Today's date: ________________ Date of birth: ________________ Gender: M F

First name: __________________________ First name: __________________________ MI: _______

Daytime phone: __________________________ Home phone: __________________________

Cell phone: __________________________ Email: ____

Do you want to have a health newsletter sent monthly? Yes No

Address: ____

City: __________________________ State: _____ Zip: _______________

Marital status: _____________ Occupation: ____

Person to notify in emergency: __________________________

Daytime phone: __________________________ Relationship: __________________________

Last physical exam: ________________ By doctor: __________________________

Family Doctor: __________________________ Phone number: __________________________

May I contact these doctors for your past health records? Yes No

Family History:

	IF LIVING		**IF DECEASED**	
	Age	**HEALTH** Good, Fair, Poor	Death Age	Death Cause
Father				
Mother				
1. Brother Sister				
2. Brother Sister				
3. Brother Sister				
4. Brother Sister				
5. Brother Sister				
Husband Wife				
1. Son Daughter				
2. Son Daughter				
3. Son Daughter				
4. Son Daughter				
5. Son Daughter				

Any blood relatives who have or had any of the following:

	Yes	No	Relationship		Yes	No	Relationship
Asthma				Hay Fever			
Arthritis				Insanity			
Allergies				Kidney Disease			
Anemia				Leukemia			
Alcoholism				Migraine			
Bleeding Disorders				Nervous Breakdown			
Cancer				Obesity			
Colitis				Rheumatism			
Congenital Heart				Rheumatic Fever			
Diabetes				Stroke			
Epilepsy				Suicide			
Goiter				Stomach Ulcers			
High Blood Pressure				Tuberculosis			
Heart Disease							

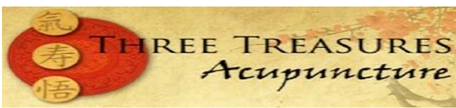
Habits:

	Yes	No	Daily Consumption Per Day
Smoke			__________ packs
Drink coffee			__________ cups
Drink liquor/wine			__________ ounces
Drink beer			__________ ounces
Fall asleep easily			
Awaken early			

Operations you've had and year:

Diseases or serious illnesses requiring hospitalization:

Diseases or serious illnesses NOT requiring hospitalization:



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Medications:

Antacids	Blood Thinning Pills	Iron or Poor Blood	Vitamins
Antibiotics	Cortisone	Laxatives	Water Pills
Aspirin, Bufferin, Anacin	Cough Medicine	Phenobarbital	Weight Reducing Pills
Barbiturates	Digitalis	Shot	Others:
Birth Control Pills	Hormones	Thyroid Pills	
Blood Pressure Pills	Insulin, Diabetic Pills	Tranquilizers	

Drugs you are allergic to:

Describe any serious injuries or accidents you have had:

Describe briefly you present medical symptoms and anything else we should know about your health: