Healthful Life MD
Getting healthy from the inside out
1030 Johnston Road, #360, Golden, CO 80401
http://healthfullifemd.com

Patient Medical History Form

Name: _____ Age: _____ Sex: M F

Primary Care Physician: _____ Phone:_____

Primary Care Physician Address: _____

_____

Present Status:

1. Do you have any medical conditions or health problems for which you are currently under the care of a doctor? Yes_____No_____

2. What Conditions?

3. Are you taking any prescription medications? Yes_____No_____

Medication Dosage

4. Are you taking any over-the-counter (non-prescription) medications, vitamins or supplements on a regular basis? Yes_____No_____

Product Dosage

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5. Are you allergic to any medications? Yes_____No_____
   Please list medication and reaction:

6. Are you currently smoking? Yes_____No_____How much?_____packs per day

   How long have you smoked?_____

7. If you are not currently smoking, did you ever smoke? Yes_____No_____

   How much?_____packs per day. How long have you smoked?_____

8. Do you drink alcohol? Yes_____No_____ How much each week?_____

   What kind of alcohol do you drink (i.e. beer, wine, liquor)? _____

9. Do you drink caffeine: Yes_____No_____ How much?_____

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10. Please mark if you have ever had or if you currently have any of the following medical conditions:

High blood pressure		Glaucoma		Vitamin Deficiency Which?		Liver Disease	
Diabetes		Kidney disease		Anemia		Heart valve problem/disorder	
Heart attack		COPD		Thyroid disease		Gout	
Chest pain		Asthma		Psychiatric illness		Gall bladder disease	
Heart failure		Lung disease		Tuberculosis		Eating disorder	
Swelling feet (edema)		Rheumatic fever		Cancer Type:		Osteoporosis	
Headaches		Depression		Thyroid disease		Other:	
Migraines		Anxiety		Drug Abuse			
Constipation		Ulcers		Blood transfusion			
Sleep apnea		Reflux		Arthritis			

11. Have you had any surgeries? Yes_____No_____
What surgeries have you had?

12. When was your last tetanus vaccine? _____Did it have the pertussis booster?_____

13. Did you have a flu shot this year?_____

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14. Have you ever had chicken pox or the vaccine? Chicken pox ____ Vaccine____Date:_____

15. For women are you:

✎ Pre-Menopausal ✎ Peri-Menopausal ✎ Post-menopausal ✎ Don't Know

Pregnancies: Number:_____ Dates:_____

Natural Delivery or C-section:_____

Menstrual history: Onset_____

Duration:_____
Are they regular? Yes_____No_____
Pain associated? Yes_____No_____

Last menstrual period: _____

Are you on hormone replacement therapy? Yes_____No_____

If yes, what are you taking?_____

_____

Are you taking birth control pills? Yes_____No_____

If yes, what are you taking?_____

_____

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16. Family History:

	Age	Health	Disease	Cause of Death	Overweight ?
Father					
Mother					
Brothers:					
Sisters:					

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Has any blood relative ever had any of the following:

	√ for yes	Who?		√ for yes	Who?
Diabetes			Liver disease		
Heart disease			Kidney problems		
Early heart disease: diagnosed before 50 years old for men, 60 for women			Cancer What type:		
High Cholesterol			Psychiatric disorder		
High blood pressure			Depression		
Asthma			Stroke		
Lung Disease			Thyroid problems		
Obesity			Gout		