CLIENT NAME: ____

MEDICAL HISTORY FORM

CLIENT MEDICAL HISTORY		
Name of primary care provider/doctor:	Date of last physical exam: Month_____________ Year _______________	Date of last dental exam: Month___________ Year ______________
Medication allergies ☐ Yes ☐ No Type:	Overnight hospitalizations: ☐ Yes ☐ No Reason:	Medications (prescription, over the counter, and/or vitamins): ☐ Yes ☐ No Names and dosages: ....
Food allergies (i.e. eggs, yeast) ☐ Yes ☐ No Type:	Surgeries: ☐ Yes ☐ No Type:	
Allergies (i.e. dust, pollen) ☐ Yes ☐ No Type:	Broken bones: ☐ Yes ☐ No Describe:	
Bee Sting Allergy ☐ Yes ☐ No	Preferred pharmacy:	

ADD/ADHD ☐ Yes ☐ No	Asthma ☐ Yes ☐ No	Diabetes (high blood sugar) ☐ Yes ☐ No
Learning special needs ☐ Yes ☐ No	Shortness of breath ☐ Yes ☐ No	Cancer ☐ Yes ☐ No
Headaches/migraines ☐ Yes ☐ No	Heart problem ☐ Yes ☐ No	Stomach problems ☐ Yes ☐ No
Seizure ☐ Yes ☐ No	Murmur ☐ Yes ☐ No	Kidney/urinary problems ☐ Yes ☐ No
Eczema/rashes ☐ Yes ☐ No	Hypertension (high blood pressure) ☐ Yes ☐ No	Depression ☐ Yes ☐ No
Anemia (low iron/blood count) ☐ Yes ☐ No	Fainting ☐ Yes ☐ No	Anxiety ☐ Yes ☐ No
		Other (please specify) ☐ Yes ☐ No

Additional information: ____
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FAMILY MEDICAL HISTORY	
Please check all conditions that apply	Please note which relative has/had this condition (parent, sibling, grandparent, etc)
☐ Asthma/emphysema/COPD	
☐ Hypertension (high blood pressure)	
☐ High cholesterol	
☐ Cancer (please specify type)	
☐ Diabetes (high blood sugar)	
☐ Stroke	
☐ Seizures	
☐ Kidney problems	
☐ Heart problems (please specify)	
☐ Mental health concerns (please specify):	
☐ Death under age 50 Cause:	
☐ Other	

Additional information: ____
____

Resource assistance	
Would you like information from our staff regarding the following: ○ Options for health insurance? ☐ Yes ☐ No ○ Finding a health care provider? (doctor or nurse practitioner) ☐ Yes ☐ No ○ Finding a dentist? ☐ Yes ☐ No	Do you have concerns about the emotional well-being of yourself/your child? ☐ Yes ☐ No Are you concerned about your income meeting the basic needs of your family? ☐ Yes ☐ No Please circle your concerns: Food Clothing Housing Paying heat/water bills Transportation to medical or school appts
Do you or any of your family have anything you would like to discuss with the counselor? ☐ Yes ☐ No	***If you answered YES to any of the above, a member of our staff will contact you.***

***Signature of parent/guardian**: ____________________________________ Date: ________________

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For office use:

Reviewed with client: ____ Date: ____________