Health History

SIDDALL MEDICAL SERVICES, INC.

Patient Name: ____________________ Today's Date: ____________________

Your Physician: ____________________ Other Physicians: ____________________

Reason for visit:

Any allergies and reactions you have (medications, foods, pollens, animals):

List medications you are taking and dosages (prescribed, over the counter, other):

List any surgeries you had had, hospitalizations, dates, & reasons:

List any known medical problems you have:

Briefly state your parents' health and the # of siblings and children:

Mother: Father: Siblings: Children:

Tell us about your family medical history by circling YES or NO.

If yes, list who is affected (e.g. father, sibling, child)

High Blood Pressure	Yes	No	Who:
Heart Disease	Yes	No	Who:
Diabetes	Yes	No	Who:
Cancer	Yes	No	Who:
Asthma	Yes	No	Who:
Thyroid Disease	Yes	No	Who:
Emphysema	Yes	No	Who:

Mark Immunizations/Vaccines you have had and when, if known:

Flu Pneumonia Tetanus TB Hepatitis A Hepatitis B

Smoking history: Alcohol History:

Occupation: Special Diet:

Medical equip used (e.g. eye glasses, hearing aids, etc.):