

# General History Form

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Reason you are seeing the doctor? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

What symptoms are you having? \_\_\_\_\_

Do you suffer from any medical conditions such as diabetes, heart disease, high blood pressure, etc.?

No  Yes – List \_\_\_\_\_

Past surgeries and dates: \_\_\_\_\_

Have you undergone treatment for drug/alcohol abuse or emotional problems?  No  Yes – date and facility: \_\_\_\_\_

Smoking history?  No  Yes – amount and duration: \_\_\_\_\_

Who is your family physician? \_\_\_\_\_

Do you see any other physicians? \_\_\_\_\_

Current medications: \_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_

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**UPDATED & REVIEWED**

**DATE** \_\_\_\_\_ **BY** \_\_\_\_\_

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