James C. Wasson, M.D.

Medical History Form

Patient _____ Date of Birth _____
First Name **Middle Initial** **Last Name**

□ Seasonal Allergies □ Drug Allergies _____ Reaction_____
□ No Known Drug Allergies

Reason for Visit Today _____

Occupation _____

Medical History – List Current Diagnosed Problems	Current Medications	Dosage	Frequency

Family History: **From the list, check any conditions that may apply to your family history.**

Mother □ Alive and Well □ Deceased **Father** □ Alive and Well □ Deceased

Family History	NO	YES/Relation?
Heart Disease		
High Blood Pressure		
Stroke		
Cancer		
Glaucoma		
Diabetes		
Epilepsy / Convulsions		

	NO	YES/ Relation?
Bleeding Disorder		
Kidney Disease		
Thyroid Disease		
Mental Illness		
Osteoporosis		
Psoriasis		
Autoimmune Disorder		

Hospitalizations: **List hospitalizations for operations or serious illnesses (excluding pregnancy)**

Year	Reason

Year	Reason

Social History:

Do you:	YES	NO
Smoke / Vape (circle)		
Packs daily? _____		
# Years? _____		
Interested in stopping?		
Drink alcohol		
How much? _____		
Type of alcohol:		
Drug Abuse		
How much? _____		
Drug type:		

Women only:	YES	NO
Are you pregnant?		
Are you planning pregnancy?		

	YES	NO
Do you have a living will?		

List **Hospital** Preference**:**

List **Pharmacy** Preference**:**

_____

Additional Medication Record

Patient Name: _____**DOB**: _____

Current Prescription Medications

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Over the Counter Medications, Herbal therapies and Supplements / none

1._____

2. _____

3. _____

4._____

5. _____

6. _____

Are there any medications that you are currently taking that you are having difficulty taking or experiencing side effects?

_____

Medication allergies and reaction

_____

Current Pharmacy and location

_____