James C. Wasson, M.D.

Today's Date _____

Medical History Form

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

Allergies _____ Drug Allergies _____ Reaction _____

Reason for Visit _____

Occupation _____

Medications: **List all medications you are currently taking, prescribed and over the counter, including frequency and dosage amount.**

Medications	Dosage	Frequency

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		
Drug Abuse		
How much? _____		
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:

_____

_____