Basin Clinic Medical History Form

Please Print

Name: _____ DOB: ____/____/_____ Visit Date: _____

Reason for visit [ ] Establish as a New patient [ ] Annual Exam [ ] Specific Concern

Past Medical History / Chronic Conditions

Ex: High blood pressure, diabetes, heart disease, etc....

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Past Surgical History

Ex: C-Section, Gall bladder removal, Fractures, etc...

Procedure Approx. Year

1. _____
2. _____
3. _____
4. _____
5. _____

Past Hospitalization within last 2 years

Why Where

1. _____
2. _____
3. _____

Family History

Illness Alive/Deceased

Mother: _____

Father: _____

Siblings: _____

Grandparents: _____

Social History Please circle

Who do you live with? Self Spouse Family Others

Employed Retired

If employed, line of work _____

Coffee: No Yes # of cups/day _____

Smoking: Never Quit Smoking

Yes # of packs / day _____# of years _____

Alcohol: Never Quit Drinking

Yes # of drinks/ day _____ Week _____

Social Drinker

Exercise: No Yes How often _____

Marijuana Use: Yes No

Recreational Drugs: Yes No

Name _____

Please Print

Medications:

Daily Prescriptions Meds	Dose	Frequency

Pain Meds/ As Needed Meds	Dose	Frequency

OTC Meds/Supplements	Dose	Frequency

Allergies

Name	Reaction

Health Maintenance

Date of Last Annual Physical: _____

Vaccination: [ ] Flu _____ [ ] Tetanus _____

[ ] Pneumonia _____ [ ] Other, Specify _____

Cancer Screening: Colonoscopy N Y, If yes when _____

Women: Mammogram N Y, If yes when _____

Pap Smear N Y, If yes when _____

Bone Density N Y, If yes when _____

Men: PSA N Y, If yes when _____