MDS DEMOGRAPHIC/MED HISTORY FORM

Nickname: _____

FULL LEGAL NAME_____
First name MI Last name Date of Birth Age

MAILING ADDRESS_____

PRIMARY PHONE NUMBER _____ ☐ HOME ☐ WORK ☐ MOBILE

SECONDARY PHONE NUMBER_____ ☐ HOME ☐ WORK ☐ MOBILE

☐ MALE ☐ FEMALE SSN # _____ EMAIL _____

Emergency contact: Name _____ Phone _____

Guarantor (Under 18)_____ Relationship to Patient_____

How did you hear about us?_____

MEDICAL HISTORY (mark all that you have had or currently have) ☐ NONE

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial fibrillation
☐ Bone marrow transplant
☐ BPH (enlarged prostate
☐ Breast cancer
☐ Colon cancer
☐ COPD (lung disease)
☐ Coronary artery disease
☐ Diabetes
☐ ESRD (kidney failure)
☐ GERD (GI reflux)
☐ Gout
☐ Heart attack
☐ Hepatitis
☐ High Cholesterol
☐ HIV/ AIDS
☐ Hypertension
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Leukemia
☐ Lung Cancer
☐ Lymphoma
☐ Prostate Cancer
☐ Seizures
☐ Radiation treatment
☐ Other _____

☐ History of recurrent infections, MRSA, or Staph?

DERMATOLOGIC HISTORY (mark all that you have had or currently have) ☐ NONE

☐ actinic keratosis
☐ basal cell skin cancer
☐ squamous cell skin cancer
☐ melanoma
☐ other skin disorder _____
☐ abnormal/precancerous moles
☐ family member w skin cancer
who? _____type? _____
☐ other skin diseases in your family _____

SURGICAL HISTORY (mark all that you have had) ☐ NONE

☐ Cancer surgery _____
☐ Heart procedure _____
☐ Orthopedic surgery _____
☐ Transplant _____
☐ Other _____

MEDICATIONS_____ ☐ NONE

_____

ALLERGIES_____ Type of reaction_____ ☐ NONE

ADDITIONAL INFORMATION

CURRENT OR PAST SMOKER? _____CONSUME ALCOHOL_____ AMOUNT AND FREQUENCY?_____

ADVERSE REACTION TO DENTAL ANESTHESIA/GENERAL ANESTHESIA? ☐ YES ☐ NO

HAVE YOU HAD THE FOLLOWING VACCINES THIS YEAR? FLU: Y OR N PNEUMONIA: Y OR N

DO YOU HAVE AN ADVANCED DIRECTIVE? Y OR N

OCCUPATION_____ EMPLOYER_____

FAMILY MEDICAL HISTORY (please list immediate family health history)

Mother_____Father_____

Sibling_____Other_____

_____ _____

Patient Signature Doctor Signature

Revised 3/2018