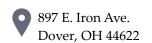


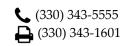
Tuscarawas County Health Department

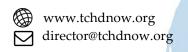
Medical Office

Patient Medical History Form

			Chart #:
Personal Ir	nformation:		
Name:			
Address: _			
Date of Bir	rth: Age:	Email:	
Gender ass	ssigned at Birth:		
o Ma	ale		
o Fe	emale		
o p	prefer not to answer		
I identify n	my gender as:		
o M a	ale		
o Fe	emale		
o No	on-Binary		
o <u> </u>	O(Fill in blank if needed)		
o l p	prefer not to answer		
Race: (Sele	ect all that apply)		
Native	American or Alaskan NativeAsian	African American	Caucasian
Native	Hawaiian or Other Pacific IslanderOtl	ner	
Are you Hi	ispanic or Latino? YES NO		
Are you en	mployed? YES NO Where	e?	
Allergies: _			









Any Religio	ous or Cultural customs we should be aware of?			
	ous or Cultural customs we should be aware of?			
Do vou sm				
Do you smoke tobacco, use marijuana, or vape? If yes, how much?				
For How lo	ong?			
Alcohol Use? #Drinks per Day				
Recreation	nal Drug Use? Type?			
Concerns or Symptoms for Todays Visit:				
Preferred F	Pharmacy:			
Past Medic	cal History			
	abetes			
o Th	nyroid Issues			
о Ну	ypertension			
o Hig	gh Cholesterol			
o Ca ı	ardiac Issues (AFib, Heart Failure, Heart Attack, Congenital Heart Disease, Murmur)			
o Lui	ing Issues (Asthma, COPD, Emphysema, Reactive Airway Disease)			
o Dig	gestive Issues (GERD, Crohn's, Colitis, Liver Disease, Diverticulitis)			
o Kid	dney Disease			
o Ne	eurological Issues (Parkinsons, Strokes, Mini Strokes, Seizures)			
o Ble	eeding or Clotting issues			
o Ca	nncer			
o Au	uto Immune Disease			
o Art	thritis			
o He	earing or Vision Issues			
o Otl	ther			

Family	History (Mother, Father, Siblings)		
0	Diabetes		
0	Thyroid Issues		
0	Hypertension		
0	High Cholesterol		
0	Cardiac Issues (AFib, Heart Failure, Heart Attack, Congenital Heart Disease, Murmur)		
0	Lung Issues (Asthma, COPD, Emphysema, Reactive Airway Disease)		
0	Digestive Issues (GERD, Crohn's, Colitis, Liver Disease, Diverticulitis)		
0	Kidney Disease		
0	Neurological Issues (Parkinsons, Strokes, Mini Strokes, Seizures)		
0	Bleeding or Clotting issues		
0	Cancer		
0	Auto Immune Disease		
0	Arthritis		
0	Hearing or Vision Issues		
0	Other		
Му Ме	dication List:		
Patient	/Parent/Guardian Signature: Date:		
	2/19/23ado.		