Public Health
Prevent. Promote. Protect.
Tuscarawas County Health Department

Tuscarawas County Health Department

Medical Office

Patient Medical History Form

Chart #: _____

Personal Information:

Name: _____

Address: _____

Date of Birth: _____ Age:_____ Email:_____

Gender assigned at Birth:

- **Male**
- **Female**
- **I prefer not to answer**

I identify my gender as:

- **Male**
- **Female**
- **Non-Binary**
- **_____(Fill in blank if needed)**
- **I prefer not to answer**

Race: (Select all that apply)

___Native American or Alaskan Native ___Asian ___ African American ___Caucasian

___Native Hawaiian or Other Pacific Islander ___Other_____

Are you Hispanic or Latino? YES NO

Are you employed? YES NO Where? _____

Allergies: _____

897 E. Iron Ave.
Dover, OH 44622

(330) 343-5555
(330) 343-1601

www.tchdnow.org
director@tchdnow.org

Social History:

Primary Language: _____ Translator Needed? _____

Any Religious or Cultural customs we should be aware of? _____

Do you smoke tobacco, use marijuana, or vape? _____ If yes, how much? _____

For How long? _____

Alcohol Use? _____ #Drinks per Day_____

Recreational Drug Use? _____ Type? _____

Concerns or Symptoms for Todays Visit: _____

_____

Preferred Pharmacy: _____

Past Medical History

- Diabetes
- Thyroid Issues
- Hypertension
- High Cholesterol
- Cardiac Issues (AFib, Heart Failure, Heart Attack, Congenital Heart Disease, Murmur)
- Lung Issues (Asthma, COPD, Emphysema, Reactive Airway Disease)
- Digestive Issues (GERD, Crohn's, Colitis, Liver Disease, Diverticulitis)
- Kidney Disease
- Neurological Issues (Parkinsons, Strokes, Mini Strokes, Seizures)
- Bleeding or Clotting issues
- Cancer
- Auto Immune Disease
- Arthritis
- Hearing or Vision Issues
- Other _____

Past Surgical History

_____

_____

Family History (Mother, Father, Siblings)

- Diabetes
- Thyroid Issues
- Hypertension
- High Cholesterol
- Cardiac Issues (AFib, Heart Failure, Heart Attack, Congenital Heart Disease, Murmur)
- Lung Issues (Asthma, COPD, Emphysema, Reactive Airway Disease)
- Digestive Issues (GERD, Crohn's, Colitis, Liver Disease, Diverticulitis)
- Kidney Disease
- Neurological Issues (Parkinsons, Strokes, Mini Strokes, Seizures)
- Bleeding or Clotting issues
- Cancer
- Auto Immune Disease
- Arthritis
- Hearing or Vision Issues
- Other _____

My Medication List:

_____

_____

_____

_____

_____

_____

Patient/Parent/Guardian Signature: _____ Date: _____

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