Charis Health Center
Medical History Form

Date ________________

Name ____ Date of Birth ______________________

List all medications that you are currently taking (prescription and over the counter), dosages, and frequency:

_____________________________________ _______________________________________
_____________________________________ _______________________________________
_____________________________________ _______________________________________
_____________________________________ _______________________________________

Allergies: ___________________ Severity: Mild Moderate Severe Reaction: ________________
___________________ Severity: Mild Moderate Severe Reaction: ________________
___________________ Severity: Mild Moderate Severe Reaction: ________________

Surgeries: ____________________________
____
____
____

Have you ever had a blood transfusion? ______

Have you been hospitalized for anything other than surgeries? ______ If yes, please explain.
____

Have you visited an emergency room within the last 3 months? ______ If yes, please explain.
____

Have you ever been diagnosed with the following?

Diabetes __________
Tuberculosis __________
Heart Disease __________
Gastrointestinal Disease __________
Thyroid Disease __________
Abnormal Pap Smears/Cervical Treatment __________
High Blood Pressure __________
Endometriosis __________
Respiratory Disease __________
Seizure Disorder __________
Cancer __________

Do you have any family history of the following? If yes, please explain.

High Blood Pressure ____________________
Diabetes ____________________
Heart Disease ____________________
Cancer ____________________
Tuberculosis ____________________

Do you use any of the following?

Cigarettes __________ If yes, how much/often? ________________________________
Alcohol ____________ If yes, how much/often? ________________________________
Recreational Drugs? __________ If yes, how much/often? ________________________________

Rev. 11/01/17