Medical History Form

Ronald G. Zelt, MD

Confidential Record: Information contained here is part of your medical record in this office and will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in making decisions regarding your care.

Name _____ Date _____
Last First Mi

Address _____
Street City Province Postal Code

Home Phone _____ Date of Birth _____
mm/dd/yyyy

Cell Phone _____ E-mail _____

How were you referred to us? How did you become aware of us? (check all that apply)

☐ Physician name _____ ☐ Friend's Name _____ ☐ Website

☐ Other _____

Age _____ Height _____ Weight _____ DOB _____

Current medications: _____

_____

Allergies to Medication: _____

_____

Surgical Operations and Dates: _____

_____

Do you have or have you had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	High blood pressure	☐	☐	Migraines	☐	☐	Stomach ulcer
☐	☐	Diabetes	☐	☐	Epilepsy/seizures	☐	☐	Hepatitis
☐	☐	Heart attack	☐	☐	Bronchitis	☐	☐	Colitis
☐	☐	Angina/heart failure	☐	☐	Asthma	☐	☐	Arthritis
☐	☐	Rheumatic disease	☐	☐	Pneumonia	☐	☐	Kidney stone
☐	☐	Congenital heart disease	☐	☐	Tuberculosis	☐	☐	Bladder infection (UTI)
☐	☐	Stroke	☐	☐	Hay fever	☐	☐	Leukemia
☐	☐	Cancer	☐	☐	Tonsilitis	☐	☐	Bleeding disorders
☐	☐	Thyroid disease	☐	☐	Cold sores	☐	☐	HIV/AIDS

Other illnesses: _____

Psychiatric disorders: _____

Do any family members have a history of any of the above? If yes please specify:

Have you ever smoked? Yes No If yes, please specify the amount _____

Drink alcohol? Yes No If yes, please specify the amount _____