Delaware Medical Care Associates, LLC

Medical History Form

Patient Name: _____ DOB: _____

Patient Address: _____

Phone Number(Home)_____ (Cell)_____

Email: _____

Primary Care Dr: _____ Referring Dr Name: _____

Pharmacy Name/Location_____

Drug Allergies/Sensitivities: _____ Height_____ Weight_____

(Check) IF YES	Past/Present Medical History		Medication/Dosage (Provide List OR Print clearly)
	High Blood Pressure		
	Diabetes		
	Cancer type_____		
	Heart Disease		
	Asthma		
	Bronchitis		
	Pneumonia		
	Tuberculosis		
	Hay Fever		
	Anxiety		
	Anemia		
	Obstructive Sleep Apnea		
	COPD		

Family history

Mother

☐ Deceased
☐ Alive

Father

☐ Deceased
☐ Alive

Check below if either parent has history of the following and write which one

☐ Cancer _____
☐ Hypertension _____
☐ Heart Disease _____
☐ Diabetes _____
☐ Stroke _____

Immunization History

Flu Vaccine YES or NO

*If yes, date*_____

Pneumovax Vaccine YES or NO

*If yes, date*_____

Covid-19 Vaccination YES or NO

If yes, date _____

Social History

Illegal Drug Use Yes or No

Alcohol Use Yes or No

Tobacco Usage: CIRCLE BELOW

Current Former Nonsmoker

If Current OR Former selected:
_____YRS PackPerDay_____

Race/ Ethnicity

☐ American Indian/ Alaskan
☐ Asian
☐ Hawaiian/Pacific Island
☐ Black/ African American
☐ White
☐ Hispanic
☐ Other Race