Northern Illinois Medical Associates

Medical History

Medical History Form

Full Name: _____ **Date of Birth:** ____/____/____ **Phone Number:** _____

Reason for Visit: _____

_____

Last PCP/Provider Other Curent Specialists:

_____

_____

_____

_____

Medical History

Please check if you have ever had any of the following conditions and date diagnosed:

- ☐ Asthma
- ☐ Allergies
- ☐ Seizures
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Sleep Apnea
- ☐ Gastrointestinal Problems
- ☐ Depression
- ☐ Stroke
- ☐ Other: _____

Surgical History

Have you had any of the following surgeries? Please check all that apply and include dates

- ☐ Appendectomy
- ☐ Hernia Repair
- ☐ Knee Surgery
- ☐ Heart Surgery
- ☐ Hip Replacement
- ☐ Cesarean Section
- ☐ Kidney Surgery
- ☐ Prostate Surgery
- ☐ Spinal Surgery
- ☐ Breast Surgery
- ☐ Other: _____

Current Medications

Please list any medications you are currently taking:

_____

_____

Allergies

Do you have any allergies? Please list them below.

_____

_____

Signature _____ Date ____/____/____

2560 Hauser Ross Drive
STE 450
Sycamore, IL 60178

1750 N Randall Rd
STE 100
Elgin, IL 60123

1000 S Randall Rd
STE 225
Geneva, IL 60134

www.nimamed.com
contact@nimamed.com

Northern Illinois Medical Associates

Medical History

Medical History Form Cont.

Full Name: _____

Date of Birth: ____/____/____

Testing History

Please list the dates of your most recent testing of the following (if applicable):

Last Mammogram ____/____/____

Last Colonoscopy ____/____/____

Last Diabetic Eye Exam ____/____/____

Last Pap Smear ____/____/____

Last DEXA Scan ____/____/____

Social History

Please answer the following:

Tobacco Use (circle one) **Current Use** **Former Use** **Never Used**

Do you drink alcohol? _____ If so, how often? _____ If so, how often? _____

Do you use marijuana? _____

Past Hospital Admissions & Dates

Please list reason and dates of recent hospital admissions:

_____

_____

Family Medical History

Please list medical conditions of immediate family members:

_____

_____

Immunization History

Please list the dates you last received the following immunizations:

Last Influenza Vaccine ____/____/____

Last Covid Vaccine ____/____/____

Last Pneumonia Vaccine ____/____/____

Signature _____ Date ____/____/____

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