TEMPLE UNIVERSITY®
Employee Health Services

Patient ID

Employee Health - Medical History Form

Current Medical Conditions
Those that you are currently experiencing and/or receiving treatment for (such as diabetes, high blood pressure, migraine)

	Please List	Date of onset (mo/yr)		Please List	Date of onset (mo/yr)
1		/	4		/
2		/	5		/
3		/	6		/

Past Medical Conditions
Those that you have had in the past but have recovered from (such as childhood asthma, gestational diabetes)

	Please List	Date of onset (mo/yr)		Please List	Date of onset (mo/yr)
1		/	3		/
2		/	4		/

Surgeries/Hospitalizations
List type of surgery (such as gall bladder) or condition for which you were hospitalized (such as heart attack, pneumonia)

	Please List	Date (mo/yr)		Please List	Date (mo/yr)
1		/	4		/
2		/	5		/
3		/	6		/

When was your last visit to the emergency room? _____ For what symptom/condition? _____

Medications
Please include non-prescription medications, vitamins, and herbal supplements in addition to prescription medications

1		4		7	
2		5		8	
3		6		9	

Please list any medication allergies: _____

Family History
Please list any conditions that run in your biological family (even if relative is deceased)

	Please List	Circle affected relative		Please List	Circle affected relative
1		Father / Mother / Sister / Brother / Child / Grandmother / Grandfather	5		Father / Mother / Sister / Brother / Child / Grandmother / Grandfather
2		Father / Mother / Sister / Brother / Child / Grandmother / Grandfather	6		Father / Mother / Sister / Brother / Child / Grandmother / Grandfather
3		Father / Mother / Sister / Brother / Child / Grandmother / Grandfather	7		Father / Mother / Sister / Brother / Child / Grandmother / Grandfather
4		Father / Mother / Sister / Brother / Child / Grandmother / Grandfather	8		Father / Mother / Sister / Brother / Child / Grandmother / Grandfather

Social History

Do you smoke cigarettes? ☐ yes / ☐ no / ☐ used to smoke, but quit	If yes, how many cigarettes per day? _____ Per week? _____
How many alcoholic drinks do you consume per day? _____ Per week? _____	Do you use illicit/illegal drugs? ☐ yes / ☐ no
How many minutes of exercise do you get per day? _____	How many days a week do you exercise? _____
How many hours of television do you watch per day? _____	How many times do you eat fast food per week? _____

Reviewed By: _____ Date: ____/____/_____