Sievering Clinic
Vienna

Medical History Form

As a new patient, you have a lot of background to share with us. Use this template when you are visiting for the first time. Fill this out to bring with you to the appointment to simplify the registration process. Keep a copy for your records so that it is available when needed to visit other doctors.

IMPORTANT: The information you entered is not saved to protect your privacy. Please print this page after entering the data so you don't lose your information.

Is there anyone in your family with heart disease, high blood pressure, diabetes, kidney, cancer or other medical problems?

Yes ☐ No ☐

If you answered Yes, please list any conditions and select how the person is related to you.

Condition: _____ Relationship: _____

Condition: _____ Relationship: _____

Condition: _____ Relationship: _____

Condition: _____ Relationship: _____

Condition: _____ Relationship: _____

List your current physicians.

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Enter the date of your last physical exam and list the physician who saw you.

Month: _____ Day: _____ Year: _____

Physician: _____

Women only

Enter the date of your last OB/GYN exam and list the physician who saw you.

Month: _____ Day: _____ Year: _____

Physician: _____

List any medical conditions you have and for how long you've had the condition (first month/year diagnosed)

Condition: _____ Month: _____ Year: _____

Condition: _____ Month: _____ Year: _____

Condition: _____ Month: _____ Year: _____

Condition: _____ Month: _____ Year: _____

Have you ever gone to an Emergency Room for treatment in the last year?

Yes ☐ No ☐

How many times in the past year?

List the reason and when you made each ER visit.

Reason: _____ Month: _____ Day: _____

Reason: _____ Month: _____ Day: _____

Reason: _____ Month: _____ Day: _____

Reason: _____ Month: _____ Day: _____

Have you ever stayed in the hospital overnight during the past year?

Yes ☐ No ☐

How many times in the past year?

List the reason and when you stayed overnight.

Reason: _____ Month: _____ Day: _____

Reason: _____ Month: _____ Day: _____

Reason: _____ Month: _____ Day: _____

Reason: _____ Month: _____ Day: _____

Have you had surgery?

Yes ☐ No ☐

List the type of surgery or reason for surgery including dates.

Reason: _____ Month: _____ Year: _____

Reason: _____ Month: _____ Year: _____

Reason: _____ Month: _____ Year: _____

Reason: _____ Month: _____ Year: _____

List any allergies to food or medications.

_____

_____

_____

_____

Have you ever had an anaphylactic reaction (turning red, overall swelling, difficulty breathing)?

Yes ☐ No ☐

Do you smoke?

Yes ☐ No ☐

Select which products you use, how much, and number of years used.

Tobacco product: Cigarettes ☐ Cigars ☐ Pipes ☐ Tobacco ☐ Chew ☐

How much:_____ Years: _____

Do you drink alcohol?

Yes ☐ No ☐

Beer: none ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ or more ☐

Wine: none ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ or more ☐

Liquor: none ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ or more ☐

Do you take any recreational drugs?

Yes ☐ No ☐

Are you taking any prescription drugs currently?

Yes ☐ No ☐

List drugs, dosage, and how often you take them.

Drug:_____ Name:_____ Dosage:_____

How often: Daily ☐ Multiple times/day ☐ Weekly ☐ Several times/week ☐ Monthly ☐

Several times/month ☐ As needed ☐

To avoid errors, bring in any medications your child takes in their original bottles.