MEDICAL HISTORY

For Office Use Only
BP: _____
Pulse: _____
Temp: _____

Date: _____

NAME: _____ **BIRTHDATE:** _____

Current Review:
Height: _____ feet _____ inches Weight: _____ lbs.

List all allergies you have
(indicate NA if NO allergies)

_____
_____
_____
_____
_____
_____

Current medications
(include vitamins, herbs and over the counter medications):

Drug	Dosage	Prescribed by

If more medications, please attach a list

If you are 65 or older, have you had a bone density test? ☐ Yes when: _____ ☐ No

Social History:

Do you smoke? ☐ Yes ☐ No
If no, did you ever smoke? ☐ Yes ☐ No
When did you quit? _____
Do you drink alcoholic beverages? ☐ Yes ☐ No
Type: _____ Amount/Frequency: _____

Have you ever used recreational drugs? ☐ Yes ☐ No
If yes, type(s) used: _____
Are you at risk for HIV (AIDS)? ☐ Yes ☐ No
(for example: blood transfusion(s), drug use, unprotected sexual contact)
Please explain: _____

Past History: Please check any that you have or have had in the past

☐ Heart Problems ☐ Thyroid Disease ☐ Diabetes ☐ Hypertension

Surgical History: List all previous operations and dates:

(1) _____
(2) _____
(3) _____
(4) _____

Surgical Risk Factors:

Have you been treated for blood clots? ☐ Yes ☐ No
If yes, where was the blood clot located: ☐ Leg(s) ☐ Lung(s) what side was the blood clot on? ☐ Right ☐ Left

Check the following concerning surgery problems that apply to you or relatives during or after surgery:

☐ bleeding disorder	☐ No problems	☐ Yes (myself)	☐ Yes (relative)
☐ anesthesia	☐ No problems	☐ Yes (myself)	☐ Yes (relative)

Did any of your relatives die during or soon after surgery? ☐ Yes ☐ No

If yes, please explain: _____

Family History:

Please list any serious medical problems that your blood relatives have experienced

Relative _____ ☐ living ☐ deceased
Problem _____
Relative _____ ☐ living ☐ deceased
Problem _____
Relative _____ ☐ living ☐ deceased
Problem _____

Systems Review: CHECK ANY OF THE FOLLOWING SYMPTOMS OR CONDITIONS YOU HAVE HAD OR NOW HAVE

Bleeding Problems	☐ bleeding disorder	☐ anemia	☐ bleeding tendencies
Eye & Vision	☐ eye pain or redness	☐ loss, change or double vision	☐ excessive watering
Ears & Hearing	☐ loss of hearing or buzzing	☐ chronic ear infections	☐ excessive drainage
Nose & Throat	☐ frequent nosebleeds ☐ excessive sneezing	☐ hoarseness ☐ blocked nasal passages	☐ frequent drainage or large quanity of sputum ☐ difficulty swallowing
Sleep	☐ daytime sleepiness/fatigue ☐ restless sleep	☐ loud/irregular snoring ☐ observed apnea	
Respiratory	☐ tuberculosis ☐ emphysema ☐ pneumonia	☐ asthma ☐ pain with breathing ☐ wheezing	☐ excessive cough ☐ bloody sputum ☐ becomes short of breath easily even during rest periods
Cardiovascular	☐ heart attack ☐ anemia ☐ heart murmur ☐ stroke ☐ rheumatic fever	☐ abnormal or fast heartbeat ☐ calf cramps when walking ☐ abnormal low blood pressure ☐ fingers or toes are always cold	☐ phlebitis ☐ chest pain ☐ varicose veins ☐ frequent swelling in ankles and/or feet
Gastrointestinal	☐ liver problem ☐ ulcer ☐ pancreatitis ☐ colitis ☐ jaundice	☐ gallbladder trouble ☐ frequent nausea or vomiting ☐ lack or loss of appetite ☐ frequent or severe constipation ☐ recurring diarrhea	☐ stomach or abdominal pain ☐ digestion difficulties or frequent belching ☐ persistent anal itch ☐ hemorrhoids or piles ☐ blood in your stools ☐ bloody vomitus
Genitl-Urinary	☐ frequent urination ☐ painful urination ☐ excessive urine ☐ difficulty with urination ☐ abnormality of testicles ☐ stricture	☐ prostatitus ☐ changes in breast or nipples (swelling, pain, lumps, discharge, irritation, infection) ☐ infertile ☐ chronic urgency ☐ abnormal or painful menses	☐ flank pain ☐ penile pain ☐ scrotal swelling ☐ vaginal pain ☐ tubal infections ☐ uterine fibroids or tumors
Neurological	☐ tension headaches ☐ migraine headaches ☐ epilepsy or seizures ☐ tropical disease	☐ severe or frequent headaches ☐ unusual head or neck tension ☐ shaking or twitching spells ☐ paralysis of the limbs ☐ frequent or constant numbness	☐ polio ☐ convulsions ☐ severe memory lapses ☐ blackouts ☐ dizziness
Psychological (Emotional)	☐ emotional illness ☐ nervous breakdown ☐ insomnia ☐ excessive worry	☐ recurrent feelings of hopelessness ☐ recurrent feelings of loneliness ☐ feelings of worthlessness ☐ constant unhappiness	☐ hysterical/panic attacks ☐ severe tension ☐ frequent crying ☐ frequent nightmares
Musculoskeletal	☐ dislocated joint ☐ torn cartilage ☐ torn ligament ☐ torn muscle(s) ☐ torn tendon(s) ☐ bone infection ☐ joint swelling ☐ arthritis ☐ tendinitis	☐ bursitis ☐ severely sprained joint ☐ joint laxity ☐ joint pain ☐ gout ☐ brittle bones ☐ soft bones ☐ bone cyst	☐ loss of joint motion ☐ painful bone spurs ☐ curved spine ☐ osteoporosis ☐ fractures ☐ ruptured disc or sciatica ☐ neck or back pain ☐ amputation

Other medical condition not already listed: _____

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____