MEDICAL HISTORY

Date:_____

NAME:_____ **BIRTHDATE:**_____

List all allergies you have: (indicate N/A for NO allergies)

_____ _____

_____ _____

_____ _____

_____ _____

If you are 50 or older, have you had a bone density test? **Yes, when:**_____ **No**

Social History:

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)? **(for example: blood transfusion(s), drug use, unprotected sexual contact)** **Yes** **No**

Please explain: _____

_____

_____

Past History: Please circle 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)** **Blood Clot was on the?** **Left** **Right**

Circle the areas concerning surgery problems that apply to you or your relatives during or after surgery:

Bleeding Disorder: **No problems** **Yes, for myself** **Yes, for relative**

Anesthesia: **No problems** **Yes, for myself** **Yes, for 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

Gentil-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:** _____

Patient Name _____ DOB _____

Patient Signature _____ Date _____

DAILY MEDICATIONS

Medication *__P__ = Prescribed **OC** = Over the Counter					**Prescribing Doctor**	**Regimen**			
Name	Strength	Reason	P	OC	Doctor's Name	A.M.	Noon	P.M.	Bedtime
Estradiol Tab (ex.)	*2 MG*	*Menopause*	*X*		*Dr. Bones*	*N/A*	*N/A*	*N/A*	*1 Tablet*

Physician Signature _____ Date ____/____/____