PATIENT MEDICAL HISTORY

HEIGHT_____ WEIGHT_____

Name_____ Date of Birth_____Age_____

Main reason for today's visit:_____

Date symptoms began: _____ What medications have you received for this?_____

What lab work or x-rays have you had for this? _____

Where was it performed? _____

Who is your primary care physician? (First and last name) _____

If patient is a child, with whom do they live? _____

Does the child attend day care? ☐ Yes ☐ No _____

PERSONAL MEDICAL HISTORY

Please Check If You Have Or Have Had Any Of The Following Illnesses Or Conditions:

- ☐ Heart Trouble
- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Alcohol Abuse
- ☐ Stroke
- ☐ Diabetes
- ☐ Hepatitis, Jaundice, or Liver Condition
- ☐ Bleeding Tendency
- ☐ Arthritis
- ☐ Latex Allergy
- ☐ Kidney Condition
- ☐ Thyroid Disease
- ☐ Cancer
- ☐ AIDs
- ☐ Psychiatric Problems
- ☐ Epilepsy with Seizures
- ☐ Emphysema
- ☐ Sexually Transmitted Disease

OTHER:_____

List Medications:

Name	Strength	Dosage

List Any Drug Allergies:

_____

_____

_____

_____

REVIEW OF SYSTEMS

Please check any of the following conditions that apply to the patient:

EYES:	☐ Failing vision	☐ Double vision			
EARS:	☐ Drainage	☐ Hearing loss	☐ Dizziness	☐ Noise in ears	
NOSE:	☐ Nasal obstruction	☐ Nosebleeds	☐ Sinus	☐ Drainage	
THROAT:	☐ Frequent sore throat	☐ Lump in Neck	☐ Hoarseness		
LUNGS:	☐ Shortness of breath	☐ Frequent cough			
HEART:	☐ Irregular heart beats	☐ Chest Pain			
G.I.:	☐ Stomach pain	☐ Indigestion	☐ Nausea	☐ Vomiting	
G.U.:	☐ Problems urinating	☐ Painful urinating	☐ Bleeding	☐ Headaches	☐ Hair loss
OB:	☐ Currently Pregnant				
N.S.:	☐ Memory loss	☐ Convulsions	☐ Seizures		
ENDO:	☐ Heat/Cold intolerance	☐ Weight gain	☐ Weight loss	☐ Hiatal Hernia	☐ Blood transfusion
	☐ HIV/AIDs risk factors	☐ IV drug abuse			

PREVIOUS SURGERY

Surgery:	Date	Surgeon/Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER MEDICAL CONDITION

Women, are you pregnant? ☐ No ☐ Yes

Do you have allergies? ☐ No ☐ Yes

Did you ever take allergy shots? ☐ No ☐ Yes

Do you take allergy shots? ☐ No ☐ Yes

How long? _____

SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes

How many years? _____

Do you drink alcohol? ☐ No ☐ Yes

If yes, frequency? _____

FAMILY HISTORY

Do you have a family history of: (immediate family only… parents, siblings)

☐ Bleeding Problems	☐ Stroke	☐ Heart disease
☐ High cholesterol level	☐ Cancer	☐ Sugar Diabetes
☐ High blood pressure	☐ Allergies	☐ Asthma

FOR OFFICE USE ONLY

I have reviewed the information on this form and found it to be relevant and accurate as of this date.

M.D. _____ Date: _____