

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:

- | | |
|--|--|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Condition |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy with Seizures |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Hepatitis, Jaundice, or Liver Condition |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> 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: _____