



MEDICAL HISTORY

Please Print

Today's Date: _____

BP: _____ Ht.: _____ Wt.: _____

Patient Name: _____ D.O.B. _____ Sex: _____

HEALTH HISTORY OF THE PATIENT

	Yes	No
Anesthesia Problems		
Asthma		
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Acid Reflux		
Nasal Allergies		
Seizures		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		
Alcoholism		
Serious Injuries		
Lung Disease		
Tuberculosis		
Phlebitis		
Anemia		
HIV/AIDS		
Liver Trouble		
Thyroid Trouble		
Stomach Ulcer		
Sleep Apnea		
Other Illnesses		
Explain all Yes answers		

FAMILY HISTORY

	Yes	No
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Anesthesia Problems		
Seizures		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		
Alcoholism		
Other		
Explain all Yes answers		

Cause of death of parents, or brothers or sisters

REVIEW OF SYMPTOMS CONTINUED

Have you recently had or do you now have:

	Yes	No
Persistent Snoring		
Hoarseness		
Difficulty Swallowing		
Chest Pain/Discomfort		
Abnormal Heartbeat		
Shortness of Breath		
Calf Cramps While Walking		
Ankle Swelling		
Cough		
Wheezing		
Pain on Breathing		
Coughing Blood		
Heartburn		
Nausea/Vomiting		
Stomach Pain		
Frequent Belching		
Frequent Loose Bowel Movement		
Frequent Constipation		
Blood in Bowel Movements		
Hemorrhoids		
Frequent Urination		
Burning on Urination		
Blood in Urine		
Difficulty Starting Urination		
Getting up Every Night to Urinate		
Flank Pain		
Joint Aches		
Muscle Aches		
Swollen Glands		
Bleeding Problems		
Easy Bruisability		
Hair Loss		
Constantly Thirsty		
Constantly Hungry		
Hot or Cold Spells		
Rashes		
Hives		
Hair Changes		
Frequent Headaches		
Seizures		
Blackouts		
Tremors		
Numbness		
Tingling		
Insomnia		
Anxiety/Panic		
Depression		
Women Only		
Are you Pregnant?		
Are You Nursing?		

REVIEW OF SYMPTOMS

Have you recently had or do you now have:

	Yes	No
Chills or Fever		
Night Sweats		
Recent Weight Change		
Poor Appetite		
Fatigue		
Reading Glasses		
Changes in Vision		
Eyes Sensitive to Light		
Watery/Itchy Eyes		
Hearing Loss		
Ringin/Buzzing in Ears		
Ear Pain		
Nasal Congestion		
Nosebleeds		
Sinus Pressure		
Dry Mouth		
Gum Trouble		
Toothache		

SOCIAL HISTORY

Smoke _____ packs/day for _____ years

Alcohol: Never Occasional
 Moderate to Heavy

Drug Overuse: None
 Presently Past Problem

Most Recent Occupation: _____

Married Single Divorced

Number of Children Living _____

Number of Pregnancies _____

Presently Living Alone? Yes No

Today's Date _____

Have you had any changes in your medical condition?

___ Yes ___ No (if yes, please list below)

Do you have any changes in your medications?

___ Yes ___ No (if yes, please list below)

Do you have any new allergies to medication?

(___ None) Please list: _____

Patient signature _____

M.D. signature _____

Today's Date _____

Have you had any changes in your medical condition?

___ Yes ___ No (if yes, please list below)

Do you have any changes in your medications?

___ Yes ___ No (if yes, please list below)

Do you have any new allergies to medication?

(___ None) Please list: _____

Patient signature _____

M.D. signature _____

Today's Date _____

Have you had any changes in your medical condition?

___ Yes ___ No (if yes, please list below)

Do you have any changes in your medications?

___ Yes ___ No (if yes, please list below)

Do you have any new allergies to medication?

(___ None) Please list: _____

Patient signature _____

M.D. signature _____

Today's Date _____

Have you had any changes in your medical condition?

___ Yes ___ No (if yes, please list below)

Do you have any changes in your medications?

___ Yes ___ No (if yes, please list below)

Do you have any new allergies to medication?

(___ None) Please list: _____

Patient signature _____

M.D. signature _____