Patient Medical History

Today's Date: ___________________

Patient Name: __________________________

Patient Date of Birth: ______ /______ /______

Please tell us why you're here and any problems or concerns you need to discuss with your provider.

____

____

Personal History

Have you ever had any of the following? (Circle YES or NO)

High Blood Pressure	YES	NO	Anemia	YES	NO
Low Blood Pressure	YES	NO	Gonorrhea	YES	NO
Heart Disease	YES	NO	Alzheimer's	YES	NO
Heart Attack	YES	NO	Tuberculosis	YES	NO
Diabetes/ Type: ____	YES	NO	Stroke	YES	NO
Blood Clot(s)	YES	NO	Gout	YES	NO
Phlebitis	YES	NO	Asthma	YES	NO
Chicken Pox	YES	NO	Emphysema	YES	NO
Kidney Stone(s)	YES	NO	Cancer/ Type: ______________	YES	NO
Gall Bladder Disease	YES	NO	Chronic Bronchitis	YES	NO
Cirrhosis	YES	NO	Stomach Ulcer	YES	NO
Epilepsy	YES	NO	Other: ________________________________		

Surgical History

Surgery: Date: (MO/YR) Surgery: Date: (MO/YR)

____ ____

____ ____

____ ____

Medications

Medication Name: Strength: Frequency: Refill: YES NO

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____

____

Allergies

Medication: Reaction: Medication: Reaction:

_____________________________________ ____

_____________________________________ ____

Do you use any medications or over the counter supplements? YES NO

If so, please list here with the dosage: ____
____
____

Are you pregnant or nursing? YES NO

Family Medical History

Mother: ____
Father: ____
Siblings: ____
Grandparents/ Other Relatives: ____

Social History

Marital Status: ______________ Occupation: ____
Have you ever smoked? YES/ NO How Long? ______ Packs Per Day: ______ Quit/When: __________
Oral Tobacco? YES/NO How Hong? _______ Do you drink? YES/NO How Often? _________
Do you use recreational drugs? YES/NO Do you exercise regularly? YES/NO How Often? __________

Review of Systems

(Please **CIRCLE** any of the following you are having or have had in the past.)

Constitutional: Unexpected weight gain/loss, fever, chills, fatigue
Eyes: Corrective lenses, blurred vision, double vision, eye pain, watering, redness
ENT: Difficulty swallowing, nosebleeds, ringing in the ears, earaches, headaches
Respiratory: Shortness of breath, wheezing, chronic cough, snoring, frequent lung infections
Cardiovascular: Chest pain, palpitations, fainting, shortness of breath with activity, leg swelling
Gastrointestinal: Heart burn, nausea, vomiting, constipation, diarrhea, blood in stool, tarry stools
Musculoskeletal: Joint pain, swelling, stiffness, muscle pain, simple fracture
Neurological: Numbness, tingling, dizziness, unsteady gait, arm or leg weakness, decreased alertness
Psychiatric: Anxiety, depression, forgetfulness
Skin: Rash, itching, redness, hives, slow healing sores
Endocrine: Excess thirst, excess urination, heat intolerance, cold intolerance
Hematologic: Easy bleeding, easy bruising
Immunologic: Reaction to foods, environmental allergies, frequent illness
None of the above.

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