

Medical History

Name: _____ DOB: _____ Date: _____

Reason for visit: 1) _____

2) _____

Past Medical History: Please mark X in box for positive answers

Allergies:

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Immunizations: Pneumovax _____ Adult DT/Tetanus _____ _____

Family History—If any blood relative has suffered any of the following—please indicate which relative

<input type="checkbox"/> Allergy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney diseases
<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Stroke
<input type="checkbox"/> Dementia	<input type="checkbox"/> Heart attack	<input type="checkbox"/>

Past Medical Illnesses: Asthma Blood clots Blood transfusion Cancer Chronic lung disease
 Diabetes Diverticulosis Heart disease Hypertension Kidney stones Gout Pneumonia
 Stroke Thyroid problem Stomach Ulcers

Diagnostic Procedures: Colonoscopy _____ Bone Density _____ Mammogram _____

Hospital Admissions: Please list additional information on reverse side of form

Date	Illness or Operation	Date	Illness

Social History: Work Status _____ Occupation _____

Habits: Alcohol no yes ____ oz. per week. Smoking no yes ____ cig. per day. Other _____

Current Medications: Please list additional medications on reverse side of form

Female Menstrual History: Age of onset _____. Regular Irregular.

Menstrual Flow-- Heavy Moderate Light. Days of Flow _____. Cycle interval _____.

Birth Control yes no. Birth Control Method _____. Menopause yes no.

of Pregnancies _____ # of Live Births _____ # of Miscarriages _____ # of Living Children _____.

... More on second page ...

Name: _____ Chart#: _____

System Review: Please mark X in box for current problems

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Appetite loss | <input type="checkbox"/> Neck Mass | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Focal Neuro Symptoms |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Loss of bladder control | <input type="checkbox"/> Unusual Sensations |
| <input type="checkbox"/> Weight gain >10 lbs. | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Nausea | <input type="checkbox"/> Unsteadiness |
| <input type="checkbox"/> Weight loss >10 lbs. | <input type="checkbox"/> Cough | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Change in Wart/Mole | <input type="checkbox"/> Breast Mass | <input type="checkbox"/> Testicular mass (male) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Breast Pain | <input type="checkbox"/> Urethral Discharge (male) | <input type="checkbox"/> Mood Changes |
| <input type="checkbox"/> New Lesions | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Urinating at night | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Calf Cramps | <input type="checkbox"/> Menstrual Irregularities (female) | <input type="checkbox"/> Cold Intolerance |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Menstrual Cramps (female) | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Eye Pain | On Exertion | <input type="checkbox"/> Pelvic Pain (female) | <input type="checkbox"/> Excessive Urination |
| <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Vaginal Bleeding (female) | <input type="checkbox"/> Heat Intolerance |
| <input type="checkbox"/> Decreased Hearing | Lying Down | <input type="checkbox"/> Vaginal Discharge (female) | <input type="checkbox"/> Libido Change |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Fainting/Blacking Out | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Sexual Concerns |
| <input type="checkbox"/> Spinning sensation | <input type="checkbox"/> Elevated Blood Pressure | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Abnormal Bleeding |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Snoring | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Swelling of Extremities | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Enlarged Lymph Nodes |
| <input type="checkbox"/> Mouth Pain | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Decreased Memory | <input type="checkbox"/> |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Change in Bowel Habits | <input type="checkbox"/> Dizziness | <input type="checkbox"/> |

Signature _____