MEDICAL HISTORY FORM – PAGE 1

NAME ____________________________ AGE _____ TODAY'S DATE ____________________

OCCUPATION ____________________________________ SEX ________________________

WHO REFERRED YOU? ____

FAMILY HISTORY (List any blood relatives with the following problems)

ASTHMA __________________________ HEART DISEASE _______________________

BLEEDING DISORDER _____________ HIGH BLOOD PRESSURE _______________

CANCER __________________________ STROKE ______________________________

DIABETES _________________________ THYROID DISEASE _____________________

OSTEOPOROSIS __________________ OTHER _______________________________

MEDICATIONS, VITAMINS, MINERALS, SUPPLEMENTS, HERBS (List name and dose)

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ALLERGY TO MEDICATIONS (Name of medicine and type of reaction)

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____

OPERATIONS (Name and date)

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____

HABITS

SMOKING (PACKS/DAY) _________________

ALCOHOL (DRINKS/DAY) ________________

IMMUNIZATIONS AND TESTS (Give date you have most recently had each of these)

TETANUS SHOT ________ PAP SMEAR _________ COLONOSCOPY ___________

FLU SHOT _____________ MAMMOGRAM ________ STOOL BLOOD TEST _______

PNEUMOVAX __________ ZOSTAVAX __________ BONE DENSITY TEST _______

~ PLEASE CONTINUE ON NEXT PAGE ~

MEDICAL HISTORY FORM - PAGE 2

PLEASE CHECK TO INDICATE ANY ***RECENT*** SYMPTOMS

GENERAL
- ❒ FALLING IN PAST YEAR
- ❒ AIDS RISK FACTORS
- ❒ DEPRESSED
- ❒ FEVER
- ❒ LOSS OF APPETITE
- ❒ NERVOUS
- ❒ TIRED
- ❒ TROUBLE SLEEPING
- ❒ WEIGHT GAIN
- ❒ WEIGHT LOSS

EYES
- ❒ RED EYE
- ❒ VISUAL PROBLEMS

ENT
- ❒ DIZZINESS
- ❒ HAY FEVER
- ❒ HEADACHES
- ❒ HEARING PROBLEMS
- ❒ DENTAL PROBLEMS

ENDOCRINE
- ❒ DIABETES
- ❒ THYROID DISEASE

RESPIRATORY
- ❒ ASTHMA
- ❒ COUGHING
- ❒ COUGHING BLOOD
- ❒ SHORT OF BREATH

CARDIOVASCULAR
- ❒ CHEST DISCOMFORT
- ❒ CHEST PAIN
- ❒ HEART ATTACK
- ❒ HEART MURMUR
- ❒ HEART SKIPPING
- ❒ HIGH BLOOD PRESSURE
- ❒ HIGH CHOLESTEROL
- ❒ PALPITATIONS
- ❒ SWOLLEN ANKLES

GASTROINTESTINAL
- ❒ ABDOMINAL PAIN
- ❒ BLACK STOOL
- ❒ BLOOD IN STOOL
- ❒ CHANGE IN STOOLS
- ❒ CONSTIPATION
- ❒ DIARRHEA
- ❒ GALL STONES
- ❒ HEARTBURN
- ❒ HEMORRHOIDS
- ❒ HEPATITIS
- ❒ INDIGESTION
- ❒ JAUNDICE
- ❒ NAUSEA
- ❒ TROUBLE SWALLOWING
- ❒ ULCER
- ❒ VOMITING
- ❒ VOMITING BLOOD

UROLOGICAL
- ❒ BLADDER INFECTIONS
- ❒ BLOOD IN URINE
- ❒ BURNING ON URINATION
- ❒ FREQUENT URINATION
- ❒ KIDNEY INFECTIONS
- ❒ KIDNEY STONE

NEUROLOGICAL
- ❒ CONFUSION
- ❒ FAINTING
- ❒ NUMBNESS
- ❒ PARALYSIS
- ❒ POOR MEMORY
- ❒ SEIZURES
- ❒ STROKE
- ❒ TINGLING
- ❒ WEAKNESS

SKIN
- ❒ RASH
- ❒ ITCHING

HEMATOLOGICAL
- ❒ ANEMIA
- ❒ BLEEDING PROBLEM
- ❒ BLOOD CLOTS

MUSCULO-SKELETAL
- ❒ ARTHRITIS
- ❒ BACK PAIN
- ❒ GOUT
- ❒ SWOLLEN JOINTS

OSTEOPOROSIS
- ❒ LOW BONE DENSITY
- ❒ OSTEOPOROSIS
- ❒ BROKEN BONE

MALE ONLY
- ❒ IMPOTENCE
- ❒ PAINFUL TESTICLE
- ❒ PENILE DISCHARGE
- ❒ PROSTATE PROBLEMS
- ❒ SWOLLEN TESTICLE
- ❒ WEAK STREAM

FEMALE ONLY
- ❒ BREAST LUMP
- ❒ HOT FLASHES
- ❒ MENSTRUAL PROBLEMS
- ❒ PELVIC PAIN
- ❒ VAGINAL DISCHARGE

ANY OTHER PROBLEMS?

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Office Use Only - Revised 01/11
History Reviewed With Patient ________