MEDICAL HISTORY FORM

Name: ____________________

Birthdate: ____________________

MR#: ____________________

FORM **MUST** BE FILLED OUT PRIOR TO VISIT

History of Present Illness

What is the reason for your visit today:

Past Medical History

Please list current and past medical problems that you have been treated for:

- ☐ High blood pressure
- ☐ Cancer
- ☐ Obesity
- ☐ Thyroid disorder
- ☐ Allergy or Asthma
- ☐ Arthritis
- ☐ Alcoholism
- ☐ Reaction to Anesthetic
- ☐ Heart Trouble
- ☐ Kidney Stones
- ☐ HIV or AIDS
- ☐ Diabetes
- ☐ Bleeding Disorder
- ☐ Glaucoma
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Seizures

Illness or Medical Problem	Physician who Treated you

Past Surgical History

Surgery	Hospital	Year

Current Medications

Please list all medications you are now taking, including those you buy without a doctor's prescription (such as aspirin, cold tablets, nutritional supplements, and/or herbal medicines)

Name	Strength	Frequency

Allergies and Sensitivities

List any allergies to medications or foods that you may have and indicate how each affects you.

Allergic To	Reaction

☐ No known drug allergies

Family History

Father _____ Living _____ Deceased - Age at Death _____ Cause ____________________

Mother _____ Living _____ Deceased - Age at Death _____ Cause ____________________

*List any other illnesses in your extended family including diabetes, heart disease, cancer, stroke, thyroid problems, etc.

Family Member

____________ _____ Living _____ Deceased - Age at Death _____ Illness ____________________

____________ _____ Living _____ Deceased - Age at Death _____ Illness ____________________

____________ _____ Living _____ Deceased - Age at Death _____ Illness ____________________

____________ _____ Living _____ Deceased - Age at Death _____ Illness ____________________

Social History

Marital Status: _____ Single _____ Married _____Widowed _____Divorced Number of children_______

Any occupational hazards (like noise or chemical exposures): _____ Yes _____ No If Yes, what: ____________________

Do you/Did you smoke: _____ Yes _____ No How much ____________ # of years_____ When did you stop?_________

Do you/Did you drink: _____ Yes _____ No How much ____________ # of years_____ When did you stop?_________

Females

Age @ first period _______ Age @ last period _______ # of pregnancies _______ # of live births _______

Age at first pregnancy_____

Nutritional History

Has there been a change in your appetite in the past 6 months? _____ Yes _____ No

Have you gained or lost weight (more than 10 lbs) in 1 month without wanting to? _____ Yes _____ No

If yes, how much gain or loss? _________

Are you happy with your weight? _____ Yes _____ No

If not, are you on a diet and exercise program? _____ Yes _____ No

For women: Are you taking any extra calcium? _____ Yes _____ No

Review of Systems

____ **Eyes** (glasses/contacts, pain, excessive tearing, double vision)

____ **Skin** (itching, rash, change in moles/birthmarks)

____ **Ears/Nose/Throat** (loss or trouble hearing, ringing, drainage, sore throat, dentures, toothache, sinus pain, hoarseness)

____ **Lungs** (cough, dyspnea, positive TB test, wheezing, spitting up blood)

____ **Heart** (chest pain, palpitations/heart pounding, trouble breathing at night, ankle swelling)

____ **Hematologic/Lymphatic** (easy bruising, swollen lymph nodes)

____ **Musculoskeletal** (pain, weakness, deformity, joint swelling, twitching, chronic back pain, lack of range of motion)

____ **Gastrointestinal** (vomiting, difficulty swallowing, abdominal pain, blood in stools, heartburn, ulcers, hemorrhoids)

____ **Endocrine** (excessively hot/cold, always thirsty/hungry)

____ **Psychological** (nervousness, anxiety, depression, nightmares, trouble sleeping, memory loss)

____ **Nervous System** (head injury, seizures, loss of coordination)

____ **Female:** Vaginal/Urinary (itching/burning, discharge, STD/UTI, irregular periods/pregnancy, frequent urination)

____ **Male:** Genitals/Urinary (hernia, discharge from penis, pain/lump in testicals, STD/UTI, kidney stones)