

MEDICAL HISTORY / REVIEW OF SYSTEMS

PLEASE COMPLETE ENTIRE FORM.

Patient Name: _____	Age: _____	HEIGHT: _____	WEIGHT: _____
PLEASE FILL IN LAST KNOWN			

SURGERIES: Appendix Cesarean Hysterectomy Tonsillectomy Tubaligation
 Gallbladder Heart surgery Other _____

SERIOUS ILLNESSES YOU HAVE/HAVE HAD: _____

YOUR MEDICATIONS: (INCLUDE OVER-THE-COUNTER AND HERBALS)
CURRENTLY TAKING: NONE **OR** List all: _____
ALLERGIC to: NONE **OR** List: _____

DO YOU USE: Caffeine (coffee/soda) Nicotine (cigarettes) Chewing tobacco Alcohol Drugs _____
 How long have you been using each? <1 yr 1-5 yrs 5-10 yrs 10+ yrs How much per day/wk/etc? _____

FAMILY MEDICAL HISTORY: (Name illnesses that member(s) of your immediate family have had, such as Arthritis, Asthma, Breast Cancer, Melanoma, Other type of Cancer, Diabetes, Heart Disease/Stroke, High Blood Pressure, Kidney Disease, Tuberculosis)

Disease(s): _____	Relationship to you: _____	Disease(s): _____	Relationship to you: _____
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Check the symptoms below that you HAVE OR HAVE BEEN TREATED FOR : (No mark indicates a negative response)

<p>CONSTITUTIONAL ___ Chills/ Dizziness/ Fainting ___ Persistent or abnormal fever ___ Chronic headache/migraines ___ Frequent loss of sleep ___ Extreme weight loss/gain</p> <p>EYE, EAR, NOSE, THROAT ___ Corrective lenses ___ Blurred/Double vision ___ Glaucoma/Cataracts ___ Loss of hearing ___ Ear infections ___ Sore throat/strep throat ___ Bleeding/sore gums ___ Nosebleeds / Sinus problem</p> <p>NEURO/PSYCH ___ Seizures ___ Depression/Nervousness ___ Mental disorder</p>	<p>CARDIOVASCULAR ___ Chest pain ___ Irregular/rapid heart beat ___ Heart murmur ___ Poor circulation ___ Blood Clots</p> <p>RESPIRATORY ___ Shortness of breath ___ Pain in lungs ___ Persistent Cough</p> <p>GASTROINTESTINAL ___ Constipation / Diarrhea ___ Ulcer ___ Hemorrhoids ___ Rectal bleeding ___ Indigestion ___ Nausea</p>	<p>GENITO - URINARY ___ Blood in urine ___ Frequent/painful urination ___ Lack of bladder control</p> <p>MUSCLE/JOINT/BONE Pain, numbness, swelling in: ___ Arms ___ Hips ___ Legs ___ Back ___ Feet ___ Neck ___ Hands ___ Shoulders</p> <p>SKIN ___ Bruise easily ___ Acne / Rosacea ___ Cold Sores ___ Itching / Rash / Psoriasis ___ Change in moles/masses ___ Skin cancer ___ Scars</p>
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ALL WOMEN
Please Complete:

Last mammogram? _____
 Circle: Normal Abnormal

Had Hysterectomy? Y N
 Are you pregnant? Y N
 Did you Breastfeed? Y N

of Children / # of Pregnancies:
 _____ / _____

Have you ever had:
 ___ Breast tenderness
 ___ Lump(s) in breast
 ___ Nipple discharge

Mark any of the following conditions YOU HAVE OR HAVE HAD IN THE PAST:

___ AIDS/HIV Positive	___ Emphysema	___ Liver Disease	___ Prostate Problems
___ Arthritis	___ Epilepsy	___ Lupus	___ Rheumatic Fever
___ Asthma	___ HEART DISEASE	___ Measles	___ Scarlet Fever
___ BLEEDING DISORDERS	___ Hepatitis	___ Multiple Sclerosis	___ Stroke
___ CANCER	___ Herpes	___ Mumps	___ THYROID PROBLEMS
___ Chemical Dependency	___ High Cholesterol	___ PACEMAKER	___ Tuberculosis
___ Chicken pox	___ HIGH/LOW BLOOD PRESSURE	___ Pneumonia	___ Ulcers
___ DIABETES	___ Kidney Disease	___ Polio	___ Venereal Disease

READ AND SIGN BELOW:
 I certify that the above information is **complete and correct** to the best of my knowledge. I will not hold my doctor or his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

PATIENT/GUARDIAN SIGNATURE: _____	DATE: _____
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For Office Use Only
 Reviewed by: _____ Date: _____