PATIENT MEDICAL HISTORY

***PLEASE COMPLETE THIS ENTIRE FORM AND SIGN**

YOUR NAME: **Age:**

YOUR HEIGHT: **WEIGHT:**

REASON FOR YOUR VISIT (please list):

***DO NOT LEAVE BLANK!**

1.ALL PAST SURGERIES (CIRCLE/LIST): Appendix Csection Hysterectomy Tubal *(use reverse if needed)*
Gallbladder Heart surgery **List other/Cosmetic**_____

2.MAJOR ILLNESSES/ACCIDENTS YOU HAVE HAD:

Occupation/Job Title:

3. MEDICATIONS: ***(INCLUDE OVER-THE-COUNTER, VITAMINS, HERBALS AND TOPICALS)***
NONE____ OR List:_____

4. ALLERGIES ***(drugs, tape, latex, topicals, food, etc):*** **NONE____ OR List:** _____

5.DO YOU USE: Alcohol/Qty? Y / N_____ **NICOTINE (Smoke-cigarettes/tobacco)** Y / N
How long have you been using Nicotine? <1 yr 1-5 yrs 5-10 yrs 10+ yrs How much per day/wk/etc? _____

6.FAMILY MEDICAL HISTORY: (Illnesses that member(s) of your immediate family have had, such as Arthritis, Asthma, Breast Cancer, Melanoma, Other Cancer, Diabetes, Heart Disease/Strokes, High Blood Pressure, Kidney Disease, Tuberculosis, Chemical Dependency)

Disease(s):	Relationship to you:	Disease(s):	Relationship to you:

7. Check the symptoms below that you *HAVE A HISTORY OF*:

CONSTITUTIONAL
___ Chronic headache/migraines
___ Frequent loss of sleep
___ Extreme weight loss/gain

EYE, EAR, NOSE, THROAT
___ Contacts/Glasses
___ Dry Eyes
___ Glaucoma/Cataracts
___ Loss of hearing
___ Chronic Ear infections

NEURO/PSYCH
___ Seizures
___ Depression/Anxiety
___ Mental disorder/Psych care

CARDIOVASCULAR
___ **Chest pain**
___ **Irregular/rapid heart beat**
___ **High/Low Blood Pressure**
___ **Heart murmur**
___ **Blood Clots (you/family)**
___ **Bleeding Disorders**

RESPIRATORY
___ Shortness of breath
___ Persistent Cough
___ Sleep Apnea

GASTROINTESTINAL
___ Constipation / Diarrhea
___ Ulcer
___ **Heartburn/Acid Reflux**

GENITO-URINARY
___ Frequent/painful urination
___ Lack of bladder control
___ Lump(s) in breast/biopsy
___Abnormal Pap _____

MUSCLE/JOINT/BONE
Pain, numbness, swelling in:
___ Arms ___ Hips ___ Legs
___ Back ___ Feet ___ Neck
___ Hands ___ Shoulders

SKIN
___ Bruise easily; clots
___ Acne / Rosacea
___ Itching / Rash / Psoriasis
___ Abnormal moles/masses
___ Skin cancer
___ Scarring/keloids

(continued next column)

***_____Date-Last Phys Exam**
_____Stress Test
_____EKG

For All Women:

Last mammogram?
Date: _____ Location: _____
Circle: Normal Abnormal

Hysterectomy/Tubal? Y N

Are you pregnant? Y N

Did you Breastfeed? Y N

# of Children: _____
Children's Ages: _____

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

___ **AIDS/HIV Positive**
___ **Anemia**
___ Arthritis
___ **Asthma**
___ Blood Transfusion
___ **CANCER** _____
___ Chemical Dependency
___ Chicken pox/Shingles
___ **DIABETES**
___ Emphysema
___ Eating Disorder
___ Fibromyalgia
___ **HEART DISEASE**
___ **Hepatitis**
___ **Herpes/Cold Sores**
___ High Cholesterol
___ Kidney/Liver Disease
___ Lupus
___ Miscarriage
___ Mononucleosis
___ Measles/Mumps
___ Multiple Sclerosis
___ **PACEMAKER**
___ Pneumonia
___ Stroke
___ Suicide Attempt
___ **THYROID PROBLEMS**
___ **Tuberculosis**
___ Varicose Veins
___ Venereal Disease/STD

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:** _____

For Office Use Only
Reviewed by: Date:

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