

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)

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

OPERATIONS (Name and date)

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 ~

GENERAL MEDICAL HISTORY FORM

PLEASE CHECK TO INDICATE ANY RECENT SYMPTOMS

GENERAL

- AIDS
- 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?

Office Use Only - Revised 01/07
History Reviewed With Patient