

PATIENT MEDICAL HISTORY FORM

PATIENT NAME: _____

DATE: _____

DATE OF BIRTH: _____

OCCUPATION: _____

PAST MEDICAL HISTORY: Do you have or have you had any of the following: (Please circle answers.)

Diabetes	Yes	No	High or low blood pressure	Yes	No
Cancer	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Arthritis/Gout/Rheumatism	Yes	No
Convulsions	Yes	No	Blood Disease	Yes	No
Hay Fever or Asthma	Yes	No	Venereal Disease	Yes	No
Lung Disease	Yes	No			
Have you ever had a blood transfusion?			Yes	No	
Are you taking or have you ever taken steroids for any reason?			Yes	No	

CURRENT MEDICATIONS:

	NAME	DOSAGE (if known)	FREQUENCY
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

DRUG ALLERGIES (please list): _____

PAST SURGERIES AND DATES IF KNOWN:

1) _____ YEAR: _____	4) _____ YEAR: _____
2) _____ YEAR: _____	5) _____ YEAR: _____
3) _____ YEAR: _____	6) _____ YEAR: _____

Have you ever been advised to have a surgical procedure which has never been done? Yes No

If so, please state the procedure and when it was recommended: _____

SOCIAL HISTORY: (Please circle answers, when applicable)

1) Do you Smoke or use tobacco? Yes No If yes, how many years _____ Number of packs per day? _____
 If you have quit, when did you quit? _____ How many packs per day did you smoke? _____

2) Do you use recreational drugs? Yes No

3) Do you drink alcohol? Yes No If yes, how many drinks per week? _____
 If you no longer drink alcohol, when did you quit? _____ Number of drinks per week? _____

4) Do you work in a noisy environment? Yes No

5) Are you frequently exposed to loud noises? Yes No

6) Have you ever been in the Military? Yes No

Reason for seeing the Doctor today: _____

(PLEASE COMPLETE BACK OF FORM.)

FAMILY MEDICAL HISTORY:

	Diseases known	If deceased, cause of death
Father	_____	_____
Mother	_____	_____
Brother/Sister	_____	_____
Grandparents	_____	_____

REVIEW OF SYSTEMS: Please indicate if you are now experiencing any of the following: (Please circle answers.)

Recent weight change	Yes	No	Joint pain	Yes	No
Fever	Yes	No	Joint stiffness or swelling	Yes	No
Fatigue	Yes	No	Muscle pains or cramps	Yes	No
Headaches	Yes	No	Dizziness	Yes	No
Chest pain or angina pectoris	Yes	No	Convulsions or seizures	Yes	No
Heart trouble	Yes	No	Chronic or frequent coughs	Yes	No
Palpitation	Yes	No	Spitting up blood	Yes	No
Swelling of feet, ankles or hands	Yes	No	Shortness of breath	Yes	No
Slow to heal after cuts	Yes	No	Burning or painful urination	Yes	No
Bleeding or bruising tendency	Yes	No	Kidney stones	Yes	No
Anemia	Yes	No	Blood in urine	Yes	No
Diabetes	Yes	No	Incontinence	Yes	No
Excessive thirst or urination	Yes	No	Moles that are irritated or bleeding	Yes	No
Very dry, flaking skin	Yes	No	Sores that have not healed	Yes	No
Eye disease or injury	Yes	No	Rash or itching	Yes	No
Blurred or double vision	Yes	No	Change in skin color	Yes	No
Glaucoma	Yes	No	Varicose veins	Yes	No
Loss of appetite	Yes	No	Change in hair or nails	Yes	No
Frequent diarrhea, nausea or vomiting	Yes	No	Snoring	Yes	No
Abdominal pain or heartburn	Yes	No	Sleep apnea	Yes	No
Peptic ulcer (duodenal or stomach)	Yes	No	Sinus problems	Yes	No
Memory loss or confusion	Yes	No	Nasal blockage	Yes	No
Nervousness	Yes	No	Hoarseness	Yes	No
Depression	Yes	No	Difficulty swallowing	Yes	No
Insomnia	Yes	No	Hearing loss or ringing in ears	Yes	No
Thyroid problems	Yes	No	Nose bleeds	Yes	No
			Bleeding gums or mouth sores	Yes	No

If the answer to any of the above is yes, please explain: _____

Patient Signature _____ Nurse/M.A. Signature _____

REVIEWED BY DOCTOR _____ DATE: _____