MEDICAL HISTORY

PLEASE FILL THIS OUT COMPLETELY, YOUR ANSWERS WILL AFFECT YOUR TREATMENT

NAME_____DOB_____AGE_____DATE_____

Reason for Consultation_____

Is this work related? Yes_____No_____

List all current medications:

NAME	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all current Vitamins, Herbal Supplements, Diet Aids and other Supplements.

IMPORTANT Circle all Diet Aids.

NAME	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name other doctors that you have seen in the past 12 months.

DOCTOR	REASON	DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all past major illnesses and hospitalizations:

DIAGNOSIS	WHERE	WHEN	DOCTOR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all past surgeries:

SURGERY	WHERE	WHEN	DOCTOR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all past broken bones and other major injuries:

INJURY	WHERE	WHEN	DOCTOR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had a blood transfusion? Yes_____No_____

Have you ever had any bleeding problems? Yes_____No_____

DRUG ALLERGIES: YES_____ NO_____ **LATEX ALLERGY:** YES_____ NO_____

NAME OF DRUG	REACTION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever used street or recreational drugs? Yes_____No_____

If yes, describe circumstance: _____

Do you currently smoke? Yes_____No_____ If so, how much? _____

If you have smoked in the past, for how long and when did you quit?

_____

Do you now or did you ever drink alcohol? Yes_____No_____

How much? _____

Do you drink caffeine beverages? Yes_____No_____

How much? _____

Are you currently on a diet? Yes_____No_____

Do you exercise regularly? Yes_____No_____

(**For Women Only)**

Pregnancies_____# Deliveries_____# Miscarriages/Abortions_____

Age at first pregnancy_____

Age at first period_____

Date of last period_____

Date of last Pap smear_____

Date of last Mammogram_____

PERSONAL HISTORY

(Circle any that apply to you)

HEENT

Visual loss or impairment	Hearing loss or impairment
Seizures	Headaches
Fainting spells	Hoarseness
Difficulty swallowing	Neck lumps

PULMONARY

Abnormal chest x-ray	Emphysema
Coughed up blood	Tuberculosis
Asthma, wheezing	HIV / AIDS

CARDIAC

High blood pressure	Angina (chest pain)
Heart attack	Heart murmur
Enlarged heart	Irregular heart beat
Stroke	Ankle swelling

GI

Weight change	Heartburn
Ulcers	Internal bleeding
Gallstones	Liver problems
Cirrhosis	Hepatitis
Pancreatitis	Colon problems
Constipation	Diarrhea
Hemorrhoids	Rectal bleeding

GU

Kidney infections	Kidney stones
Bladder control	Difficulty urinating

MUSCULAR-SKELETAL

Gout | Arthritis

Back problems | Slipped disk

ENDOCRINE

Diabetes | Thyroid problems

High cholesterol | Cortisone use

Hormone deficiency

HEMATOLOGIC

Anemia | Bleeding tendency

Blood clots | Poor clotting

PSYCHIATRIC

Depression | Nervous breakdown

Drug use | Alcoholism

FAMILY HISTORY

	Age	Current health status or cause of death
Father	_____	_____
Mother	_____	_____
Brothers	_____	_____
	_____	_____
Sisters	_____	_____
	_____	_____
Spouse	_____	_____
Children	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

_____

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