

MEDICAL HISTORY FORM

Patient's Name _____ DOB _____ Age ____ Referring Dr. _____

Why are you here to see the doctor today? _____

PERSONAL HABITS

Height	Weight
Nationality	
Education Level	
Occupation(s)	
Exercise (type)	
Sleep (unusual hours)	
AVERAGE AMOUNT PER DAY:	
Alcohol (type)	
Recreational drugs	
Tobacco (type)	
ALLERGIES TO MEDICINE (list)	

YOUR HEALTH HISTORY (Please include approximate dates)
MAJOR OR ONGOING ILLNESS(ES):
OPERATIONS (SURGERY):

YOUR FAMILY HEALTH HISTORY

MEDICATIONS TAKEN REGULARLY (list all)	DOSE	How Often?

Please list major illnesses, types of cancer and surgeries for each if applicable. Don't forget anyone with diabetes, stroke, high blood pressure, heart disease.

Mother: _____

Father: _____

Other: _____

Additional Comments: _____

REVIEW OF SYSTEMS

Check "yes" for any illness/disease/surgery at any time. Check "no" for all others.

<p>GENERAL</p> <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever/chills/ sweats</p> <p><input type="checkbox"/> <input type="checkbox"/> Weight Loss of more than 10 lbs</p> <p><input type="checkbox"/> <input type="checkbox"/> Change in appetite</p> <p><input type="checkbox"/> <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you exercise regularly</p> <p><input type="checkbox"/> <input type="checkbox"/> If female, have you had a hysterectomy</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you take birth control pills</p> <p>PAST MEDICAL HISTORY</p> <p>Have you been hospitalized recently? _____</p> <p>Reason _____</p> <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> <input type="checkbox"/> Valley Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> <input type="checkbox"/> AIDS/HIV</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney Stones</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Pneumonia</p> <p>SKIN</p> <p><input type="checkbox"/> <input type="checkbox"/> Rashes/ itching</p> <p><input type="checkbox"/> <input type="checkbox"/> Dryness</p> <p>HEAD</p> <p><input type="checkbox"/> <input type="checkbox"/> Head trauma/injury</p> <p><input type="checkbox"/> <input type="checkbox"/> Headache</p> <p><input type="checkbox"/> <input type="checkbox"/> Tenderness</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Vertigo</p> <p>EYES</p> <p><input type="checkbox"/> <input type="checkbox"/> Change in vision</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of vision</p> <p><input type="checkbox"/> <input type="checkbox"/> Blurring</p> <p><input type="checkbox"/> <input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> <input type="checkbox"/> Inflammation or discharge</p> <p><input type="checkbox"/> <input type="checkbox"/> Dry eyes</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive tearing</p> <p><input type="checkbox"/> <input type="checkbox"/> History of cataracts or glaucoma</p> <p>EARS</p> <p><input type="checkbox"/> <input type="checkbox"/> Hearing loss</p> <p><input type="checkbox"/> <input type="checkbox"/> Earache/discharge</p>	<p>NOSE</p> <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Change in sense of smell</p> <p><input type="checkbox"/> <input type="checkbox"/> Unusual smell</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic discharge</p> <p><input type="checkbox"/> <input type="checkbox"/> External tenderness</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive nose bleeds</p> <p><input type="checkbox"/> <input type="checkbox"/> Sensation of vomiting</p> <p><input type="checkbox"/> <input type="checkbox"/> Polyps</p> <p>MOUTH</p> <p><input type="checkbox"/> <input type="checkbox"/> Mouth pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Dry mouth</p> <p><input type="checkbox"/> <input type="checkbox"/> Bleeding gums</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcerations or lesions on gums</p> <p><input type="checkbox"/> <input type="checkbox"/> Throat Soreness</p> <p><input type="checkbox"/> <input type="checkbox"/> Unusual lumps</p> <p>THROAT</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> <input type="checkbox"/> Lumps</p> <p><input type="checkbox"/> <input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> <input type="checkbox"/> Soreness</p> <p>ENDOCRINE</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Steroid use</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood in the urine</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent infections</p> <p>RESPIRATORY</p> <p><input type="checkbox"/> <input type="checkbox"/> Cough</p> <p><input type="checkbox"/> <input type="checkbox"/> Phlegm production</p> <p><input type="checkbox"/> <input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> <input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain with breathing</p> <p><input type="checkbox"/> <input type="checkbox"/> Expectoration</p> <p>NEUROLOGICAL</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> <input type="checkbox"/> Vertigo</p> <p><input type="checkbox"/> <input type="checkbox"/> Periodic weakness of extremities</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizures/convulsions</p> <p><input type="checkbox"/> <input type="checkbox"/> Significant headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Confusion</p> <p><input type="checkbox"/> <input type="checkbox"/> Memory loss for recent events or remote events</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Balance problems</p> <p>PSYCHIATRIC</p> <p><input type="checkbox"/> <input type="checkbox"/> Mental health problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Suicidal tendencies</p> <p><input type="checkbox"/> <input type="checkbox"/> Major depression</p>	<p>GASTROINTESTINAL</p> <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Nausea/Vomiting</p> <p><input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Vomiting blood</p> <p><input type="checkbox"/> <input type="checkbox"/> Changes in bowel movements</p> <p><input type="checkbox"/> <input type="checkbox"/> Changes in stool</p> <p><input type="checkbox"/> <input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> <input type="checkbox"/> Heartburn/ulcer symptoms</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Pancreas problems</p> <p>HEMATOLOGIC</p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood transfusion</p> <p>GENITOURINARY</p> <p><input type="checkbox"/> <input type="checkbox"/> Painful/difficult urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> <input type="checkbox"/> Incontinence</p> <p>MUSCULOSKELETAL</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthralgias</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Joint swelling</p> <p><input type="checkbox"/> <input type="checkbox"/> Limited range of motion</p> <p><input type="checkbox"/> <input type="checkbox"/> Redness or tenderness</p> <p>CARDIOVASCULAR</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Tightness</p> <p><input type="checkbox"/> <input type="checkbox"/> Squeezing or fullness with/without activity</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Murmur</p> <p><input type="checkbox"/> <input type="checkbox"/> Palpitations/Irregular heart</p> <p><input type="checkbox"/> <input type="checkbox"/> Angina/chest pain, pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest pain with activity</p> <p><input type="checkbox"/> <input type="checkbox"/> Congestive heart failure</p> <p><input type="checkbox"/> <input type="checkbox"/> Mitral valve prolapsed</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you had a heart attack</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Surgery</p> <p><input type="checkbox"/> <input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> <input type="checkbox"/> Other vascular surgery</p> <p>_____</p> <p><input type="checkbox"/> <input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> High cholesterol</p> <p>Other not listed: _____</p> <p>_____</p> <p>_____</p>
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If yes to any of the above, please give details:

I have reviewed the above recorded information

Physician Signature _____

Date _____

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