

You may print and fill out our Medical History Form. Please bring this with you to your first appointment.



Medical History Form

Patient Name _____

Date of Birth _____

For Physician Use Only

Date _____

Comments _____

Date _____

Comments _____

If the physician is unable to obtain patient history from the patient or other source, describe the patient's condition or other circumstances precluding obtaining a history.

Dear Patient:

We need to know your medical history in order to provide the best care we can. Please take a few minutes to answer all questions. Add any information you believe the doctor should know about your health. If you need any help with this form, please ask us.

Thank you.

Patient's name _____ Today's Date _____

Age _____

Height _____

Weight _____

Person filling out the form - if not the patient _____

Relationship to patient? _____

Who referred you to our office? _____

Have any of your family members been treated here? _____

Why are you seeing the doctor today? _____

When did you first have this problem? _____

Past Medical History

Do you see a doctor regularly for any medical reasons? Yes No

If yes, for what reason do you see a doctor regularly? _____

Please check any of the following that you have had.

- | | | | | |
|--|--|---|------------------------------------|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> HIV | <input type="checkbox"/> AIDS | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> High Blood Pressure | | <input type="checkbox"/> Other _____ | | |

Have you had any serious injuries? Yes No

If yes, please list the date and type of injury _____

Have you had any surgery? Yes No

If yes, please list the date and type of surgery _____

Are you on a weight loss program? Yes No

Patient Name: _____ Date of Birth: _____

Do you take any prescribed medicine, non-prescribed medicine, or health supplements?

Yes No

If yes, list the name of the medication or supplement and how much you take

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergies

Are you allergic to any medications, prescribed or over the counter? Yes No

If yes, please list medication and the reaction you had. (Include aspirin, Tylenol, vitamins, over-the-counter medications, herbal remedies, etc.) _____

Are you allergic to any foods? Yes No

If yes, please list food and the reaction you had. _____

Family History

Are there diseases or illnesses that family members have had? Please check the boxes below for any family member who has had the problem. Under siblings, write brother or sister. Under grandmother and grandfather, please write in mother's or father's side.

	Mother	Father	Siblings	Grandmother	Grandfather
Anesthetic Problems					
Breast Cancer					
Colon Cancer					
Cancer (other)					
Diabetes					
Heart Disease					
High Blood Pressure					
Mental Illness					
Stroke					
Tuberculosis					

Comments _____

Patient Name: _____

Date of Birth: _____

Social History

What is your marital status? Married Single Other

What is your occupation (if retired, your past occupation)? _____

Do you smoke? Yes No

If yes, how much per day? _____

Do you drink alcoholic drinks? Yes No

If yes, how much and how often? _____

Do you take drugs for reasons that are not medical? Yes No

If yes, please list _____

Medical Conditions (adults only)

Have you had any of the following? If yes, please check. If no, please check the No Problems box.

General Health

- Recurrent infections / fever
- Excessive fatigue
- Night sweats
- Recent weight gain or loss
- Decreased appetite
- No Problems

Other: _____

Comments: _____

Skin, Breast

- Eczema or Psoriasis
- Rash / itching
- Lumps / growths
- Sores
- Changes in skin color
- Tenderness or pain in breast
- Dermatitis
- Hair loss
- Discharge from nipples
- Changes in moles
- Skin cancer
- No Problems
- Dry or scaling skin

Other: _____

Comments: _____

Eyes

- Wear glasses or contacts
- Blurred vision
- Cataracts
- Recent change in vision
- Eye infections
- No Problems

Other: _____

Comments: _____

Head, Ears, Nose, Mouth, Throat

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fullness in head | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Hearing aid | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Sore throat / infections | <input type="checkbox"/> Sinus infections |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Lip or mouth sores |
| <input type="checkbox"/> Pain / pressure in ears | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Itching in ears | <input type="checkbox"/> Nasal drainage | <input type="checkbox"/> No Problems |
| <input type="checkbox"/> Dizziness | | |

Other: _____

Comments: _____

Heart

- | | | |
|---|--|---|
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Thumping / pounding / racing heartbeat |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Swollen arm and leg, ankles | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> No Problems |

Other: _____

Comments: _____

Veins (blood vessels), lymphatic

- | | |
|---|---|
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Swollen lymph nodes (glands) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> No Problems |

Other: _____

Comments: _____

Respiratory system

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sleep on more than 1 pillow | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Cough blood or mucus | <input type="checkbox"/> Oxygen use at home | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Lung cancer | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic obstruction | <input type="checkbox"/> Pulmonary disease | <input type="checkbox"/> No Problems |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing | |

Other: _____

Comments: _____

Gastrointestinal

- | | | |
|---|---|---|
| <input type="checkbox"/> Special diet | <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Change in bowel habits |
| <input type="checkbox"/> Nausea / vomiting | <input type="checkbox"/> Swallowing difficulty | <input type="checkbox"/> Rectal bleeding |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Black or tarry stools | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Heartburn / use anti-acids | <input type="checkbox"/> Blood in vomit | <input type="checkbox"/> Stomach, liver, colon cancer |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stomach / abdominal pain | <input type="checkbox"/> No Problems |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Diarrhea | |

Other: _____

Comments: _____

Reproductive (Genitourinary)

- | | | |
|--|---|--|
| <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Sudden urge to urinate | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Burning pain when urinating | <input type="checkbox"/> Cramps | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Urinary tract, bladder, kidney infection | <input type="checkbox"/> Clots |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Cervical, ovarian, uterine cancer | <input type="checkbox"/> No Problems |

Other: _____

Comments: _____

Nervous system (Neurological)

- | | | |
|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke | <input type="checkbox"/> Coordination problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mini-stroke | <input type="checkbox"/> Uncontrolled shaking |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Concentration problems | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Memory changes | <input type="checkbox"/> Speech problems | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Fainting / losing consciousness | <input type="checkbox"/> Facial weakness / spasms | <input type="checkbox"/> No Problems |
| <input type="checkbox"/> Light headedness | <input type="checkbox"/> Muscle weakness | |

Other: _____

Comments: _____

Endocrine system

- | | | |
|---|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Temperature intolerance |
| <input type="checkbox"/> Hormone problems | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Pituitary gland problems |
| <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Excessive urination | <input type="checkbox"/> No Problems |
| <input type="checkbox"/> Thyroid disease | | |

Other: _____

Comments: _____

Immune system

- | | |
|--|--|
| <input type="checkbox"/> Environmental allergies | <input type="checkbox"/> Connective tissue disease |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Frequent colds / infections |
| <input type="checkbox"/> Food allergies | <input type="checkbox"/> No Problems |
| <input type="checkbox"/> Immune system problems | |

Other: _____

Comments: _____

Muscle, bone, joint

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Muscle cramping / spasms | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Neck / back pain | <input type="checkbox"/> Swelling | <input type="checkbox"/> No Problems |

Other: _____

Comments: _____

Psychiatric

- Anxiety
- Depression
- Considering suicide
- Panic attacks
- Sudden mood swings
- Emotional difficulties
- Insomnia
- Other psychiatric problems
- Under psychiatric care
- Desiring psychiatric care
- No Problems

Other: _____

Comments: _____

Women's Medical History

Date of first period _____ Date of last period _____

Age at menarche _____ Age at menopause _____

Number of pregnancies _____ Number of live births _____

Did you breast feed? Yes No Date of last pap smear _____

What were the results? _____ Are you on hormone therapy? Yes No

If yes, describe _____

Do you do self-exams of breasts? Yes No When was your last mammogram? _____

Other information: Please write down any other information you feel the doctor should know.
