Medical History

Name: ________________________ D.O.B. _____________ Today's Date: ___________

Height_______ Weight_______ Temperature______ Blood Pressure______ Pulse____ Respirations____

Medications including dosage:

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____
____
____
____

Allergies: Please circle any medications to which you are allergic:

Penicillin Sulfa Codeine, Morphine, Demerol, Aspirin, Adhesive Tape, Tetanus, Horse serum,
Anti-inflammatories, **NONE** Other: ____

Habits: Smoking: Yes Not Currently Never Packs per day____ Number of years______
Use of alcohol: Yes No Daily: Yes No

Today's Problem list:

____
____

Surgery:

Please list the type of surgery and date

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Hospitalizations:

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Hypertension:

Low Blood Pressure: YES or NO High Blood Pressure: YES or No

Family history:

Please check all that apply and indicate the **"RELATIONSHIP"** (Mother, Father, Aunt, Uncle, etc.)

Cancer______ Heart Attack______ Mental illness________ Diabetes______ Stroke______ Other______

Social history:

Occupation_____________________ Married or Single (circle one) Number of Children____________

Do your live alone? YES NO With someone? (circle one) Spouse Significant Other Room Mate

Review of systems:

HIV/AIDS (PLEASE CIRCLE) YES NO

Immune & Infection Problems: ____________________________, ______________________________

ENT: Glaucoma_______ Tumor_______ Other_______________

Respiratory: Pneumonia_____ COPD______ Asthma________ Hay Fever______ Other_______

Cardiovascular: Heart attack___ Peripheral Vascular Disease____ Varicose Veins____ Phlebitis___

Angina____ Palpitations____ Congestive Heart Failure____ Atrial Fibrillation_____ Other_________

Gastro Intestinal: Ulcers___ Diverticulosis____ Hiatal Hernia_____ Hemorrhoids____ Hepatitis____

Gallbladder Trouble___________ Colitis __________Appendicitis_________ Other__________

Genitourinary: Kidney Stones______ Frequent Bladder Infections_____ Kidney Infections_____

Prostate problems______ Other__________

Musculoskeletal: Gout___ Rheumatoid Arthritis____ Lupus_____ Ankylosing Spondylitis_____

Fractures_________ Other________________

Neurological: Concussion_____ Neuropathy____ Sciatica______ Meningitis____ Polio_____

Seizures______ Stroke_____ Other________

Endocrine: Diabetes_________ Thyroid disease_____ Other Endocrine Disease___________

Psychiatric: Mental illness__________ Nervous Breakdown________ Other__________

OB/GYN: Painful periods_______ Ectopic Pregnancy _________Abortion______ Miscarriage_______

PID______ C-Section________ Age of Menopause Currently _____________ Pregnant? ______

Signature of Patient or Legal Guardian:_________________________________ Date: ___/____/_____