

Medical History Form

Name _____

Date _____

Reason for today's visit _____

ALLERGIES (list reactions) _____

Latex Allergy Y or N please circle

Medications and Dosages

Vitamins, Minerals, Herbs & Supplements

Immunizations-(year)

Tetanus Toxoid _____
Hepatitis Vaccine _____
Shingles Vaccine _____
Human Papilloma Virus Vaccine _____

Pneumonia Vaccine _____
"Flu" Shot _____

Medical Conditions (Past or Present)

- AIDS/HIV infection
- Accutane use/date finished _____
- Alcoholism
- Allergic Rhinitis
- Amyloidosis
- Anemia *type _____
- Arthritis-Osteoarthritis
 - Rheumatoid
 - Psoriatic
- Bleeding Disorder
- Blood Clotting Disorder
- Boils/Wounds
- BPH (enlarged prostate)
- Breast Cancer (side)
- Breast Implants
- C.Difficile(history of)
- Cancer (type)
- Celiac Disease
- Chemotherapy (current or past)
- Cholesterol/High Lipids
- Cold Sores/Fever Blisters
- Colitis
- Connective Tissue Disease-Lupus
 - Scleroderma
- Defibrillator
- Dementia/Memory Problems
- Diabetes
- Diverticulitis/Diverticulosis
- Deep Vein Thombosis (DVT)
- Eclampsia
- Emphysema/COPD
- Eye Disorder
- Fibromyalgia
- GERD/Acid Reflux
- Glaucoma
- Globulin Disorder
- Gout
- Heart Disease(heart attack,stents,failure)

- Heavy Metal Toxicity
- Hepatitis
- High Blood Pressure/Hypertension
- Inflammatory Bowel Disease/Crohn's/Ulcerative Colitis
- Irritable Bowel Syndrome
- Joint Replacement (location _____)
- Kidney Failure/Dialysis (schedule _____)
- Kidney Stones
- Liver Disease
- Lung Disease
- Lyme Disease
- Lymphoma/Leukemia
- Migraine Headaches
- MRSA History/Exposure
- Neurologic Disorder (Type- _____)
- Organ Transplant (Type- _____)
- Osteoporosis
- Oxygen Therapy
- Pacemaker *Please provide pacemaker card to copy
- Peptic (Stomach/Duodenal) Ulcers
- Peripheral Vascular Disease
- Pulmonary Embolism
- Radiation Therapy *ANY
- Raynaud's Phenomenon
- Rosacea
- Sarcoidosis
- Scars-*Wide or Keloid
- Seizures
- Skin Cancer
- Skin Diseases- (Psoriasis/Eczema-other _____)
- Sleep Apnea-CPAP
- Spine Problems
- Stroke/TIA's
- Thalessemia
- Thyroid Disorder
- TMJ problem (temporomandibular joint)
- Tuberculosis

*Wound Healing Problems-SPECIFY _____

Bleeding Tendencies

- Do you BRUISE easily
- Do you BLEED easily

Surgical History/Operations-List ALL prior Surgeries/Dates/Complications

_____	_____
_____	_____
_____	_____

History of Anesthesia Related Problems

Psychiatric Conditions

- Alcoholism
- Attention Deficit Disorder
- Anxiety Disorder
- Bipolar Disorder
- Depression
- Mental Retardation
- Obsessive Compulsive Disorder
- Substance Abuse _____

Female Patients

- Last Menstrual Period _____
- Currently Pregnant
- Currently Breastfeeding
- History of Miscarriages
- Peri/Post Menopause

Social History

- Cigarette/Cigar/Pipe Smoking
How many years _____
- Chewing Tobacco
- Alcohol Use/How Much _____
- Recreational Drug Use
Type/Frequency _____

- Marital Status- single, married, widowed, divorced
- Children #/ages _____
- Occupation _____
- Educational Level Achieved _____
- Exercise-amt/type _____
- Hobbies _____

Family History

- Unknown family medical history
- Adopted

- Alcoholism
- Alzheimers Dementia
- Anesthesia Problems
- Asthma
- Auto Immune Disorder
- Bleeding Disorder
- Blood Clots
- Breast Cancer
- Cancer *type _____
- Diabetes
- Endocrine Disorder(hormone)
- Glaucoma
- Heart Disease
- High Blood Pressure

- Hemophilia
- Kidney Disease
- Kidney Stones
- Leukemia
- Liver Disease
- Lung Disease
- Malignant Hyperthermia
- Melanoma
- Parkinson's Disease
- Skin Disease
- Stroke
- Substance (Drug) Abuse
- Sudden Unexplained Death

Review Of Systems

*Please review and check if you have any of the following

Cardiovascular

- Chest Pain
- Leg Swelling
- Palpitations/Irregular Heartbeat
- Shortness of Breath

Constitutional

- Chills
- Fatigue
- Fever
- Headaches
- Sweats
- Weight Loss-unexplained
- Weight Loss-intentional

Eyes

- Blurred Vision
- Double Vision
- Dry Eyes
- Impaired Vision
- Watery Eyes

Ears/Nose/Mouth/Throat

- Balance Problems
- Breathing Problems
- Chronic Cough
- Ear Pain
- Nose Bleeds
- Sinus Problems
- Sore Throat
- Swallowing Difficulty
- Tinnitus (ringing in the ears)
- Vertigo

Gastrointestinal

- Abdominal Pain
- Constipation
- Diarrhea
- Difficulty Swallowing
- Nausea/Vomiting

Genitourinary

- Bladder Problems
- Burning during Urination
- Difficult Urination
- Frequent Urination
- Incontinence
- Painful Urination

Musculoskeletal

- Back Pain
- Bone Pain
- Joint Pain
- Muscle Weakness
- Stiff Joints
- Swollen Joints

Neurological

- Dizziness
- Headaches
- Numbness/Tingling
- Paralysis
- Weakness

Respiratory

- Cough
- Chest Pain-non cardiac
- Shortness of Breath
- Sputum/Phlegm
- Wheezing

Skin

- Blisters
- Dryness
- Lesions
- Rash

* **Height** _____
 * **Weight** _____

If the reason for today's visit is due to an accident please give date/details of the event _____

***The above information is true and accurate to the best of my knowledge.**

Patient Signature _____

Date _____