MEDICAL HISTORY

Name: Date:

Occupation:	DOB:	SSN#:	
Marital Status:	Phone #:	Cell#:	
Past Allergies			
PRESENT ALLERGIES			

A. Family History: If any blood relative has suffered any of the following, check and indicate which family member:

	Alcoholism		Cancer		Heart Disease		Osteoporosis
	Anemia		Diabetes		Hypertension		Stroke
	Asthma		Epilepsy		Kidney Disease		Thyroid
	Arthritis		Glaucoma		Mental Illness		
	Bleeds Easily		Hayfever/Allergies		Migraine		

B. Hospital Admissions (Do not include pregnancies): Use space on back if necessary

Year	Illness/Operation

C. List all medications and supplements you are currently taking: Use space on back if necessary

Date of last vaccine:

Tetanus:	Flu:	Pneumococcal:	Hepatitis:	

Date of last test/exam:

Cholesterol:	Dental:	Eye:	Hearing:	Sigmoid/Colonoscopy:
Pap Smear:	Complete Physical:	Mammogram:	Prostate exam:	PSA:

Check all that apply: Indicate with an **X for past condition**; indicate with **a √ current condition,**

	Decreased Hearing		Hay fever/Allergies		Swollen ankles		Jaundice/hepatitis		Hives
	Ringing in ear		Prolonged hoarseness		Fainting spells		Change in Bowels		Eczema
	Frequent ear infections		Pneumonia/Pleurisy		Leg pain		Diarrhea		Difficulty sleeping
	Dizzy spells		Bronchitis/Chronic Cough		Varicose veins/phlebitis		Constipation		Nervousness
	Failing Vision		Asthma/Wheezing		Loss of appetite		Diverticulosis		Depression
	Eye Pain		Shortness of breath		Difficulty swallowing		Crohn's/Colitis		Memory Loss
	Frequent eye infections		Chest pain		Indigestion/heartburn		Bloody/Tarry stools		Excessive Moodiness
	Recurrent Nose bleeds		High Blood Pressure		Peptic Ulcers		Hemorrhoids		Phobias
	Sinus Trouble		Heart Murmur		Abdominal pain-chronic		Hernias		Mental Illness
	Frequent sore throats		Irreg. pulse/palpitations		Gall bladder trouble		Frequent urine infections		Chicken Pox
	Cancer		Chronic fatigue		Back Pain-recurrent		Urination>2x a night		Polio
	Diabetes		Weight Loss-recent		Bone fracture		Painful, Loss of control		Mumps
	Thyroid disease		Anemia		Joint injury		Decrease in force/flow		Measles
	Concussions/seizures		Bruise easily		Gout		Kidney stones		German Measles

	Stroke		Numbness/Tingling sensation		Osteoporosis		Veneral disease/Herpes		Rheumatic Fever
	Tremor-hands shake		Headaches-frequent		Foot pain		Urethal discharge		Scarlet Fever
	Muscle weakness		Arthritis/Rheumatism		Cold numb feet		Rashes		Tuberculosis

Alcohol oz. per week:	Smoking cig. Per day X years	Coffee/tea # cups per day:

Female Menses: Please indicate all that apply and answer questions regarding your menstrual cycle:

	Flow regular		Flow irregular		Menstrual pain		Menstrual cramps		Pain /bleeding after sex

# of Pregnancies:	# of Live Births:	# of Miscarriages:	# of Abortions:

Date of last menses:	Length of cycle:	Days of flow:

Patient Signature: _____Date: _____

Person completing form if NOT patient:_____ Date_____

Relationship to patient: _____

Office Notes:

Physician signature: _____Date:_____