MEDICAL HISTORY

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Consultation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any Drug Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY** **YEAR OF IMMUNIZATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \_\_\_\_High Blood Pressure | \_\_\_\_Heart Disease | \_\_\_\_Epilepsy | \_\_\_\_\_\_Hepatitis | \_\_\_\_\_Mumps |
| \_\_\_\_Diabetes | \_\_\_\_Cancer | \_\_\_\_Kidney Disease | \_\_\_\_\_\_Pneumonia | \_\_\_\_\_Rubella |
| \_\_\_\_Asthma | \_\_\_\_Hay Fever | \_\_\_\_Migraine | \_\_\_\_\_Flu | \_\_\_\_\_Polio |
| \_\_\_\_Glaucoma | \_\_\_\_Stroke | \_\_\_\_Bleeds Easily | \_\_\_\_\_Tetanus |  |
| \_\_\_\_Mental Illness | \_\_\_\_Alcoholism | \_\_\_\_Eczema | \_\_\_\_\_Diphtheria |  |
| \_\_\_\_Anemia | \_\_\_\_Psoriasis |  | \_\_\_\_\_Measles |  |

**HOSPITAL ADMISSION** Indicate the year you were admitted into the hospital and the reason. Do Not include normal pregnancies.

|  |  |  |  |
| --- | --- | --- | --- |
| Year | Illness or Operation | Year | Illness or Operation |
|  |  |  |  |
|  |  |  |  |

**MEDICATIONS** List all medications that you are currently taking, including over the counter drugs.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medications | Strength | How Often | medication | Strength | How Often |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

HAVE YOU EVER SMOKED: \_\_\_\_YES \_\_\_\_NO \_\_\_\_\_\_\_ YEAR QUIT

STILL SMOKING? \_\_\_\_YES \_\_\_\_NO IF YES: Cigarettes Per Day \_\_\_\_\_\_\_ \_\_\_\_\_\_\_# of Years

**MEDICAL HISTORY** Check all that apply.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **\_\_Decreased hearing** | **\_\_\_Blood in stool** | **\_\_\_Glaucoma** | **\_\_\_Freq. Urine infections** | **\_\_\_Numbness/tingling** | **\_\_\_Asbestosis** |
| **\_\_\_Ringing in Ear** | **\_\_\_Venereal Disease** | **\_\_\_Cataracts** | **\_\_\_Blood in urine** | **\_\_\_Constipation** | **\_\_\_Emphysema** |
| **\_\_\_Freq. Ear infections** | **\_\_\_Hepatitis** | **\_\_\_Difficulty swallowing** | **\_\_\_Control of urination** | **\_\_\_Diverticulitis** | **\_\_\_Abnormal X-ray** |
| **\_\_\_Dizzy spells** | **\_\_\_Chest pain** | **\_\_\_Indigestion/Heartburn** | **\_\_\_Decreased force in urine** | **\_\_\_Bronchitis/chronic cough** | **\_\_\_Pulmonary Fibrosis** |
| **\_\_\_Measles** | **\_\_\_High blood pressure** | **\_\_\_Loss of appetite** | **\_\_\_Kidney Disease** | **\_\_\_Gall bladder trouble** | **\_\_\_Narcolepsy** |
| **\_\_\_Failing vision** | **\_\_\_Swollen ankles** | **\_\_\_Freq. Nausea/vomiting** | **\_\_\_Chronic fatigue** | **\_\_\_Back pain-recurrent** | **\_\_\_TB** |
| **\_\_\_Double/blurred vision** | **\_\_\_Moodiness** | **\_\_\_Peptic ulcers** | **\_\_\_Recent weight loss** | **\_\_\_Shortness of breath** | **\_\_\_Asthma/Wheezing** |
| **\_\_\_Freq. Eye infections** | **\_\_\_Heart murmur** | **\_\_\_Chronic abdominal pain** | **\_\_\_Anemia** | **\_\_\_Foot pain** | **\_\_\_Mumps** |
| **\_\_\_Nose bleeds** | **\_\_\_Irregular pulse** | **\_\_\_Change in bowel habits** | **\_\_\_Bruise easily** | **\_\_\_Cold numb feet** | **\_\_\_Polio** |
| **\_\_\_Freq sore throat** | **\_\_\_Palpitations** | **\_\_\_Diarrhea** | **\_\_\_Cancer** | **\_\_\_Rashes** | **\_\_\_German measles** |
| **\_\_\_Hay fever** | **\_\_\_Fainting spells** | **\_\_\_Pneumonia/pleurisy** | **\_\_\_Thyroid disease** | **\_\_\_Hives** | **\_\_\_Rheumatic fever** |
| **\_\_\_Allergies** | **\_\_\_Kidney stones** | **\_\_\_Hernia** | **\_\_\_Diabetes** | **\_\_\_Difficulty sleeping** | **\_\_\_Restless Leg Syndrome** |
| **\_\_\_Hoariness prolonged** | **\_\_\_Leg pain when walking** | **\_\_\_Arthritis** | **\_\_\_Convulsions/seizures** | **\_\_\_Nervousness** | **\_\_\_Gout** |
| **\_\_\_freq. headaches** | **\_\_\_Varicose veins** | **\_\_\_Jaundice** | **\_\_\_Stroke** | **\_\_\_Depression** | **\_\_\_ COPD** |
| **\_\_\_Hemorrhoids** | **\_\_\_Phlebitis** | **\_\_\_Bone fracture/joint injury** | **\_\_\_Tremor/Hands shaking** | **\_\_\_Memory loss** | **\_\_\_Sleep Apnea** |

ALCOHOL: \_\_\_\_YES \_\_\_\_NO \_\_\_\_\_ Oz. Per Week Coffee/Tea: YES/NO \_\_\_\_Cups Per Day

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_