

# MEDICAL HISTORY

Please answer all of the following questions prior to your first examination. It will help your physician to know not only about your health but also about your family.

TODAY'S DATE \_\_\_\_\_

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

EDUCATION \_\_\_\_\_ OCCUPATION \_\_\_\_\_ HOW LONG \_\_\_\_\_ EMPLOYER \_\_\_\_\_

DO YOU SMOKE? \_\_\_\_\_ HOW LONG? \_\_\_\_\_ HOW MANY PACKS/WK? \_\_\_\_\_ USE ALCOHOL? \_\_\_\_\_ HOW MUCH? \_\_\_\_\_

## FAMILY HISTORY:

	Alive	(Present health condition)	Deceased	(Cause of death)
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Spouse	_____	_____	_____	_____

	# Alive	(Any health problems)	# Deceased	(Cause of death)
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____

	# Alive	(Ages & any health problems)	# Deceased	(Ages & cause of death)
Children	_____	_____	_____	_____

Check illnesses which have occurred in your blood relatives: \_\_\_\_\_ Diabetes \_\_\_\_\_ Cancer \_\_\_\_\_ Bleeding Problems

\_\_\_\_\_ Migraine \_\_\_\_\_ Suicide \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Heart Problems

## PERSONAL HISTORY:

Family Doctor \_\_\_\_\_ Referring Doctor \_\_\_\_\_

Date of last physical \_\_\_\_\_ any abnormal findings \_\_\_\_\_

CHECK if immunized for: \_\_\_\_\_ Small Pox \_\_\_\_\_ Tetanus \_\_\_\_\_ Polio \_\_\_\_\_ Typhoid \_\_\_\_\_ Other.

OPERATIONS (Type, Date, Hospital, Surgeon)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

OTHER HOSPITAL ADMISSIONS BESIDES SURGERY (List problem, dates, hospital, admitting doctor)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

LIST ALL ALLERGIES (to medication, foods, etc.). What medication are you now taking? \_\_\_\_\_

MENSTRUATION: Date of last period \_\_\_\_\_ Onset at age \_\_\_\_\_ Regular? \_\_\_\_\_ # of Miscarriages. \_\_\_\_\_

Are you on Birth Control Pills? \_\_\_\_\_ WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_\_

What Is Your Main Reason For Your Visit Today? \_\_\_\_\_

**Circle all the things that are bothering you now or within the past year:**

**General:** fever, chills, soaking sweats, lumps

**Eyes:** eye pain, vision loss, spots or floaters, infections, injury, glaucoma, cataracts  
Date of last eye exam: \_\_\_\_\_

**ENT:** dizziness, hearing loss, ringing, ear pain, infections, sinus headaches, nasal drainage, nosebleeds, mouth bleeds, sores, voice change, difficulty swallowing

**Heart:** chest pain, palpitations, irregular pulse, high blood pressure

**Lungs:** cough, dark sputum, bloody sputum, shortness of breath, wheezing, need high pillows, awoken at night choking, asthma, bronchitis or pneumonia

**Digestive:** chronic indigestion, frequent nausea/vomiting, changes in bowel habits, diarrhea, constipation. Last hemeoccult exam (if over 50): \_\_\_\_\_

**Urinary:** burning urine, bloody urine, infection, VD, difficulty in starting stream, dribbling, get up to urinate \_\_\_\_\_ time(s) a night.

**Muscular/Skeletal:** Stiff / swollen / painful joints, weakness, bad back, varicose veins, muscle pain, history of fractures, muscle cramping, limitations on walking

**Neuro:** nervousness, paralysis, numbness, fainting, stroke, tensions, tingling, weakness, tremors or paralysis

**Blood:** anemia, bleeding tendencies, easy bruising, fatigue

**Glands:** thyroid disorder, diabetes, unexplained changes in height or weight, previous or current hormone therapy, hair change, skin change, heat/cold intolerance, loss of sex drive

**Psych:** depression, anxiety, stress-related problems

**Allergic/Immune:** eczema, hives and/or itching, frequent sneezing, chronic clear nasal discharge, conjunctivitis, any allergy that causes interference with activities of daily living

**Skin & Breast:** sores, color changes of lesions, breast pain /tenderness /swelling, history of nipple discharge / changes. Date of last mammogram: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Comment: \_\_\_\_\_ Dr. \_\_\_\_\_ Date \_\_\_\_\_

Comment: \_\_\_\_\_ Dr. \_\_\_\_\_ Date \_\_\_\_\_

Comment: \_\_\_\_\_ Dr. \_\_\_\_\_ Date \_\_\_\_\_

Comment: \_\_\_\_\_ Dr. \_\_\_\_\_ Date \_\_\_\_\_