Medical History

Please (√) symptoms you **currently have**

General

☐Chills ☐Depression/Nervousness ☐Dizziness/Fainting

☐Fever ☐Forgetfulness ☐Headache

☐Loss of Sleep ☐Loss of Weight ☐Numbness

☐Sweats ☐Other: ___________

Muscle/Joint/Bone

Pain, weakness, numbness in:

☐Arms ☐Hips

☐Back ☐Legs

☐Feet ☐Hands

☐Neck ☐Shoulders

Skin

☐Bruise Easy ☐Sores won't heal

☐Hives ☐Itching/Rash

☐Change in Moles ☐Scars

☐other: ______

Gastrointestinal

☐Appetite Poor ☐Gas ☐Vomiting

☐Bloating/Pain ☐Hemorrhoids ☐Excessive Thirst

☐Bowel Changes ☐Indigestion ☐Diarrhea

☐Constipation ☐Nausea ☐Rectal Bleeding

Eye/Ear/Nose/Throat

☐Bleeding Gums ☐Blurred Vision ☐Crossed Eyes

☐Difficulty Swallowing ☐Double Vision ☐Earache/Discharge

*Pt. Name*________________________________

Medical History (cont'd) *Pt. Name: ___________________________*

☐Hay Fever ☐Hoarseness ☐Loss of Hearing

☐Nosebleeds ☐Persistent Cough ☐Ringing in Ears

☐Sinus Problems ☐Vision-Flashes/Halos ☐other: ______________

Cardiovascular

☐Chest Pain

☐High/Low Blood Pressure

☐Irregular/Rapid Heart Beat

☐Poor Circulation

☐Swelling Ankles

☐Varicose Veins

☐Other:________________

Genito-urinary

☐Blood in Urine

☐Frequent Urination

☐Lack of Bladder Control

☐Painful Urination

☐Other:_________________

Men Only

☐Erection Difficulties

☐Lump in Testicle

☐Penis Discharge

☐Sore on Penis

☐Other:_________

Women Only

☐Abnormal Pap smear

☐Bleeding between Periods

☐Breast Lump

☐Extreme Menstrual Pain

☐Hot Flashes

Women Only (cont'd)

☐Nipple Discharge

☐Vaginal Discharge

☐Other: ____________________

Date of Last Menstrual Cycle:

______/_____/______

Date of last Pap smear:

______/_____/______

Have you had a mammogram? ☐Yes ☐No Date:______/_____/______

Are you Pregnant? ☐Yes ☐No Number of Children: ______

Pt. Name: ____

Medical History (cont'd)

Check (√) conditions you have had or currently have.

☐AIDS	☐Chicken Pox	☐HIV Positive	☐Polio
☐Appendicitis	☐Diabetes	☐Kidney Disease	☐Prostate Problem
☐Arthritis	☐Emphysema	☐Liver Disease	☐Rheumatic Fever
☐Asthma	☐Epilepsy	☐Measles	☐Scarlet Fever
☐Bleeding Disorders	☐Glaucoma	☐Migraine Headaches	☐Stroke
☐Breast Lump	☐Heart Disease	☐Multiple Sclerosis	☐Thyroid Problem
☐Cancer	☐Hepatitis	☐Mumps	☐Tuberculosis
☐Cataracts	☐Herpes	☐Pacemaker	☐Ulcers
☐Chemical Dependency	☐High Cholesterol	☐Pneumonia	☐Venereal Disease

☐Other: ____

Surgeries/Hospitalization

•Please list surgeries/hospitalizations and approx. mo/yr:

1. ________________________ 4. ______________________
2. ________________________ 5. ______________________
3. ________________________ 6. ______________________

Medications

Please list all medication you are currently taking including vitamins/supplements:

Name ____________ **Strength** ____________ **Dose** ____________

____

____

____

____

Pharmacy Name: ____

Address: ______________________ City: _____________ Zip: ________

Phone Number: (____) _______-__________

Medical History (cont'd)

Allergies

Medication	Reaction	Date

Social History

Are you sexually active? ☐Yes ☐ No

If yes, what age did you become sexually active? _________

Do you drink alcoholic beverages? ☐Yes ☐No

If yes, How much? ________________ How often? _________

Do you smoke? ☐Yes ☐No

Have you ever been a smoker? ☐Yes ☐No

How much? _____________ packs/day

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my child, ever has a change in health.

____ _____/_____/_____

Signature of Patient, Parent, Guardian or Representative Date

_________________________________ _________________________

Print Name of Patient Relationship to Patient